

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22b, Film G249 9/25/59 1wk

10323

10377

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>114 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>7139 Everglades Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ilona Benczsko ADAMS</b>		4. DATE OF DEATH Month Day Year <b>September 18 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-13-09</b>
9. AGE (In years last birthday) <b>49</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Journalist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter BENCZSKO</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>(H) Harold W. Adams, same as #2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Glioblastoma multiforme</b> 193.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 27</b> , 19 <b>59</b> , to <b>Sept. 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 18</b> , 19 <b>59</b> , and that death occurred at <b>1035PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>W. H. Druckemiller</b> M.D. <b>U. S. Naval Hospital</b> <b>9-19-59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>W. H. DRUCKEMILLER, CAPT, MC, USN</b> <b>Bethesda, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation-Shipment</b>		22b. DATE THEREOF <b>8/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George County Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>		24. REC'D BY REGISTRAR <b>SEP 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Fries</b>			

A. S. C.

POLY-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10324

10340

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK 17</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington Sq. &amp; Hosp.</u>		d. STREET ADDRESS <u>806 Forston Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>MARY GARDINER Aiken</u>		4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-99</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't. U.S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>William H. Metzler</u>		14. MOTHER'S MAIDEN NAME <u>EVA McMillan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>204-14-9207</u>	
17. INFORMATION <u>PT's hosp. record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October</u> , 19 <u>59</u> , to <u>Sept 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>59</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u>		ADDRESS (Street, city or town, state) <u>1019 University Boulevard East</u>	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		DATE SIGNED <u>9/12/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>9/15/59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		23a. NAME OF CEMETERY OR CREMATORY <u>SHENNANGO VALLEY CEMETERY</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		23b. LOCATION (City, town, or county) (State) <u>GREENVILLE, PENNSYLVANIA</u>	
24a. REC'D BY REGISTRAR <u>SEP 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

1901

NAME OF DECEASED: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DIAGNOSIS: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

SIGNATURE OF PHYSICIAN: [illegible]

SIGNATURE OF REGISTRAR: [illegible]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10378

CERTIFICATE OF DEATH

10325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG R.F.D. # 2</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LABAN BOGARD ARMSTRONG</b>		First		Middle		Last		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>29</b> Year <b>19 59</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/21/72</b>		9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>OLIVER ARMSTRONG</b>				14. MOTHER'S MAIDEN NAME <b>JANE DAVIS</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Arterio Sclerosis Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>7 days</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>9/29</b> 19 <b>59</b> to <b>9/29</b> 19 <b>59</b> , that I last saw the deceased alive on <b>9/29</b> 19 <b>59</b> , and that death occurred at <b>8:05A</b> M, from the causes and on the date stated above.													
ACTUAL SIGNATURE <b>J. W. Bird</b>		M.D. <b>Sandy Spring</b>		ADDRESS (Street, city or town, state) <b>SANDY SPRING, MARYLAND</b>		DATE SIGNED <b>9/29/59</b>							
PHYSICIAN'S NAME (Type) <b>J. W. BIRD, M. D.</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 1 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville</b>		22d. LOCATION (City, town, or county) <b>Rockville</b>		(State) <b>Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stacy Barber</b>				ADDRESS <b>Laytonsville</b>		Md.		24a. REC'D BY REGISTRAR DATE <b>OCT 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. Thorne</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITALS

1911

100-11111

1

Blank lines for recording death information.

## CERTIFICATE OF DEATH

10326

Reg. Dist. No.

10379

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Mexico</b> b. COUNTY <b>Jal</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Box 635</b> d. STREET ADDRESS <b>Box 635</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frankey Carolyn Awbrey</b>				4. DATE OF DEATH Month Day Year <b>September 4, 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 22, 1946</b> 9. AGE (In years last birthday) <b>12</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank I. Awbrey</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Gilmore</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebellar Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) <b>Multiple Splenic &amp; Renal Infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Atelectasis of Lungs</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>August 24, 1959</b> , to <b>September 4, 1959</b> , that I last saw the deceased alive on <b>September 4, 1959</b> , and that death occurred at <b>7:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>LAWRENCE A. GAYDOS, M.D.</b>				DATE SIGNED <b>9/4/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>SALINA</b>		22b. DATE THEREOF <b>9-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HERMIT, TEXAS</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W W Chambers Co</b>				ADDRESS <b>1400 Chapin St</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1031

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Signature of informant: \_\_\_\_\_

13. Name of informant: \_\_\_\_\_

14. Address of informant: \_\_\_\_\_

15. Date of completion: \_\_\_\_\_

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10341

## CERTIFICATE OF DEATH

Reg. Dist. No.

10327

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>3 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7300 BALTIMORE AVE.</u>				d. STREET ADDRESS <u>17300 BALTIMORE AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OLIVE</u> Middle <u>F.</u> Last <u>BADGER</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 12, 1867</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>DARLINGTON PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAKE FLECHMAN</u>				14. MOTHER'S MAIDEN NAME <u>RHOADES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>NINE</u>		17. INFORMANT <u>HOWARD E. CABLE, 248 PARK AVE., TAKOMA PARK, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour _____ o. m. _____ p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1/27</u> , 19 <u>57</u> , to <u>9/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/18</u> , 19 <u>59</u> , and that death occurred at <u>6:05</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Dean H. Harding</u> M.D. <u>113 Carroll St NW Wash DC 9/26/59</u> PHYSICIAN'S NAME (Type) <u>DEAN H. HARDING</u> (OVER)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>SEPT. 28, 1959</u>		<u>FT LINCOLN CEMETERY</u>		<u>BLADENSBURG RD. PRINCE GEORGE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Harding</u>				ADDRESS <u>254 CARROLL ST. NW. WASH. DC</u>		24a. REC'D BY REGISTRAR <u>SEP 29 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur H. Harding</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr Brockport, Montgomery County,  
Corpus was notified and will  
appear.

Deane Hacking MD



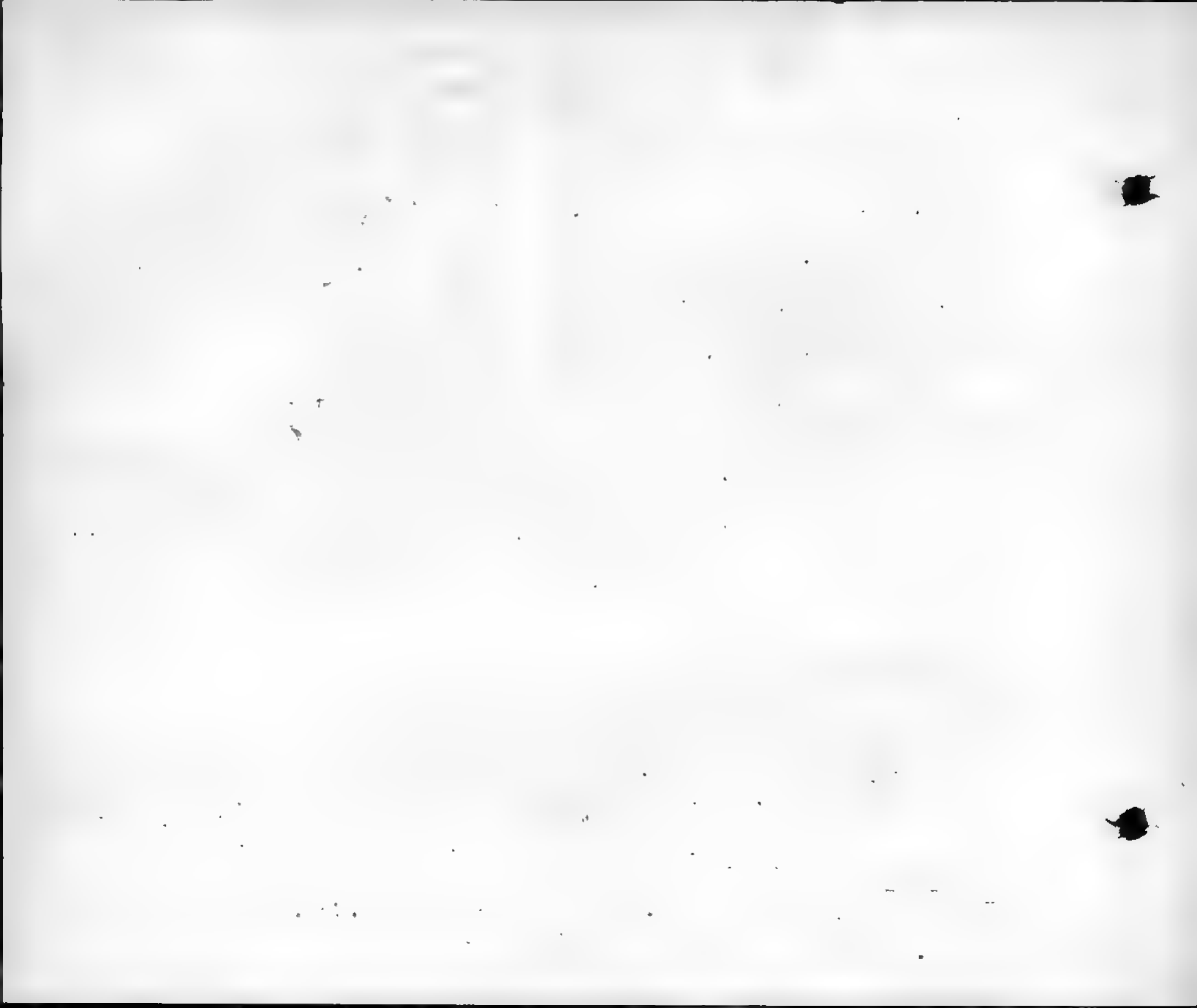
10342

CERTIFICATE OF DEATH

Reg. Dist. No. 10328

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Boaz</u> Last <u>Banes</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1959</u>		b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-94</u>	9. AGE (In years, last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Claim Settler - Gen. Acct. Off. U.S. Coast. &amp; Ge. Sur.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>America</u>		
13. FATHER'S NAME <u>Henry Banes</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Harrison</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW 2 Army</u>			16. SOCIAL SECURITY NO. <u>  </u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4 <u>  </u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Atelectasis, Rt lung</u> (c) <u>Congestive Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>? 1 week</u> <u>6 wks.</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>July</u> , 1956, to <u>Sept 14</u> , 1959, that I last saw the deceased alive on <u>Sept 14</u> , 1959, and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.			ADDRESS (Street, city or town, state) <u>2701 Canall Ave</u> DATE SIGNED <u>9-14-59</u>				
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>			SIGNATURE <u>James M. Whitlock</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pb. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Thomas</u>			ADDRESS <u>Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>Arthur E. Thomas</u> DATE <u>SEP 16 '59</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



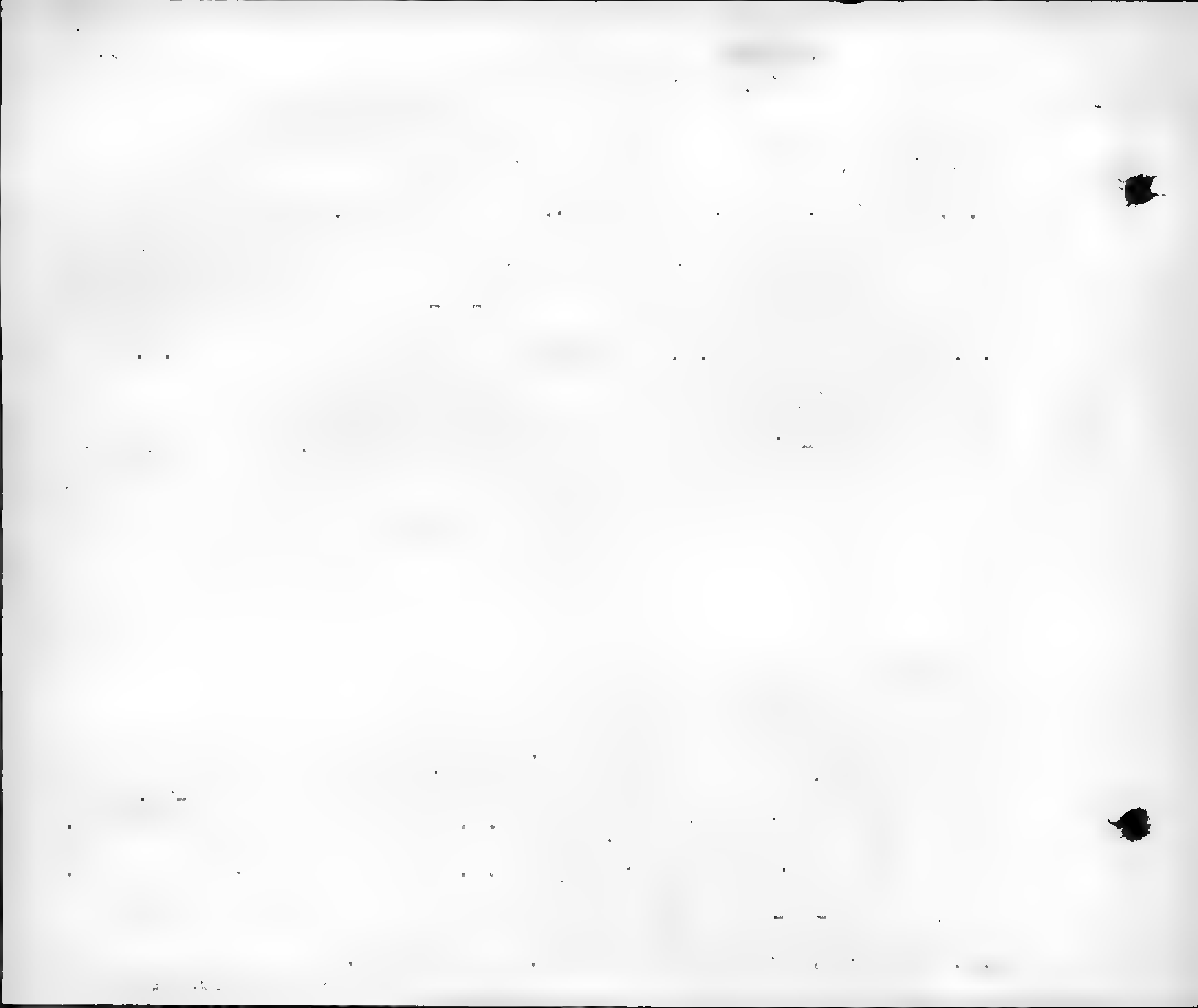
10380

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>						d. STREET ADDRESS <b>1728 Shepard Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert</b>		First <b>Harwood</b>		Middle <b>BARRETT</b>		Last		4. DATE OF DEATH Month <b>September</b>		Day <b>23</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-20-91</b>		9. AGE (in years, last birthday) <b>67</b> yrs.		10. UNDER 1 YEAR Months <b>67</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Army</b>		12. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		13. BIRTHPLACE (State or foreign country) <b>Virginia</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1913 -1951</b>	
13. FATHER'S NAME <b>George BARRETT</b>						14. MOTHER'S MAIDEN NAME <b>Danna Godwin</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>						16. SOCIAL SECURITY NO. <b>1913 -1951</b>					
17. INFORMANT <b>(Wife) Elizabeth (n) Barrett Same as #2</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Metastatic Carcinoma of bladder</b> DUE TO (c) <b>years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from <b>17 Sept.</b> , 19 <b>59</b> to <b>23 Sept.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>23 Sept.</b> , 19 <b>59</b> , and that death occurred at <b>4:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9-23-59</b> DATE SIGNED ACTUAL SIGNATURE <b>Robert T. Brooks Jr.</b> M.D. <b>U.S. Naval Hospital, Bethesda Md.</b> PHYSICIAN'S NAME (Type) <b>Robert T. BROOKS Jr. LT. MC</b> <b>U.S. Naval Hospital, Bethesda Md.</b>											
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>											
22b. DATE THEREOF <b>9-25-59</b>											
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>											
22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>											
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Humphrey, 7557 Wisconsin Ave. Bethesda Md. 59</b>											
24a. REC'D BY REGISTRAR <b>SEP 28 '59</b>											
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10381

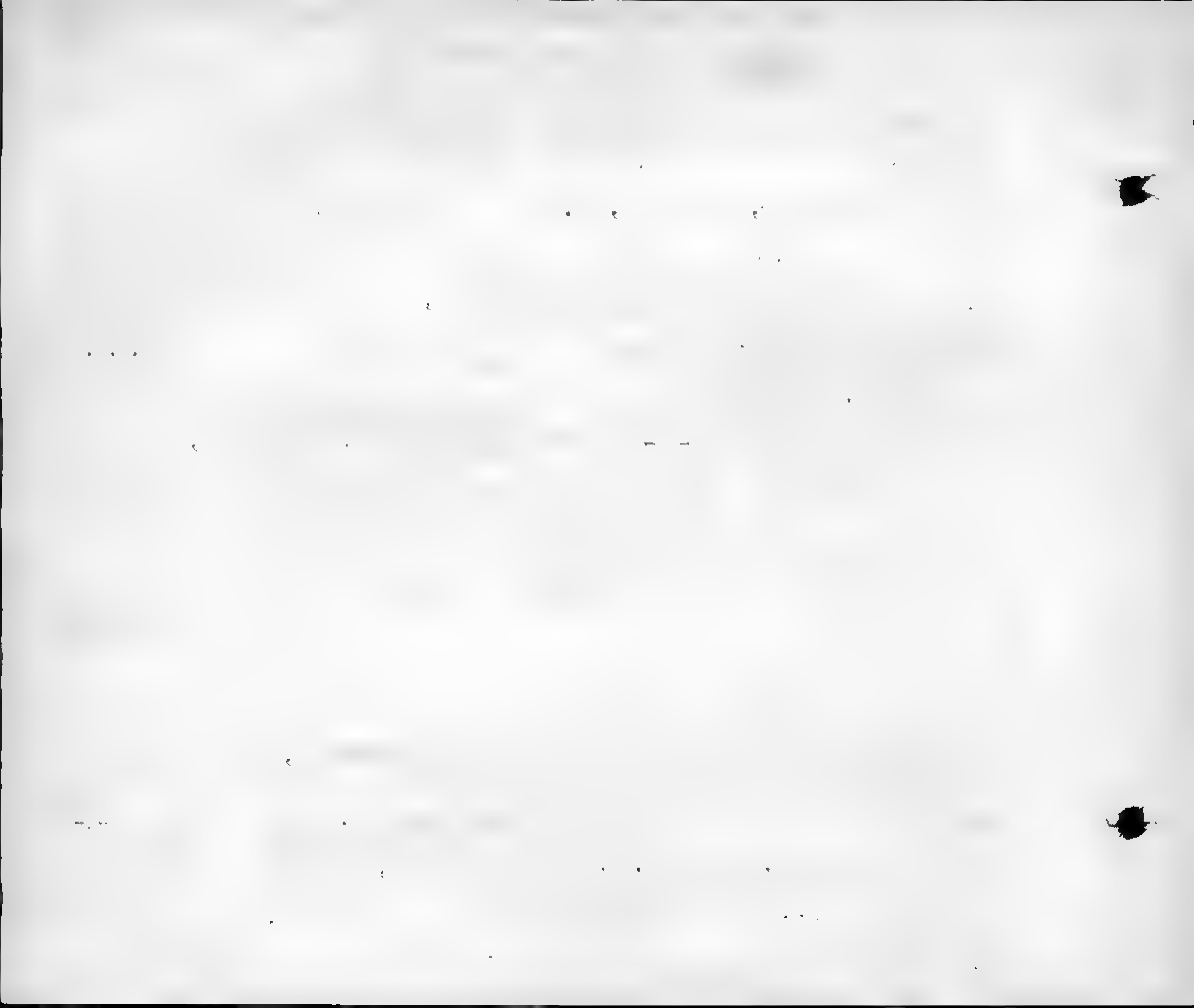
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Asheville</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>91 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>110 Annandale Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Lee</b> Last <b>Bartlett</b>				4. DATE OF DEATH Month <b>September</b> Day <b>2</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 14, 1937</b>		9. AGE (In years last birthday) <b>22</b> yrs	IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>59</b>	IF UNDER 24 HRS. Hours <b>22</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Station Attendant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Oscar E. Bartlett</b>				14. MOTHER'S MAIDEN NAME <b>Stella Spears</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>243-54-9570</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial and subarachnoid hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Acute leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>16 hours</b> <b>9 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Septicemia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>June 3, 1959</b> to <b>September 2, 1959</b> , that I last saw the deceased alive on <b>September 2, 1959</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>9-2-59</b> ACTUAL SIGNATURE <b>Lawrence A. Gaydos, M.D.</b> PHYSICIAN'S NAME (Type) <b>Lawrence A. Gaydos, M.D.</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>9-3-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hills Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Asheville, N C</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Every Funeral Home</b> By <b>Manager</b>				ADDRESS <b>Fairfax, Va.</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur A. Howard</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10382

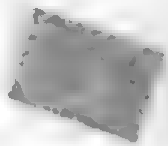
## CERTIFICATE OF DEATH

Reg. Dist. No

10331

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9011 Old Georgetown Road</b>		e. STREET ADDRESS <b>9011 Old Georgetown Road</b>	
3. NAME OF DECEASED (Type or print) First <b>ADENA</b> Middle <b>M.</b> Last <b>BATES</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>19,</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1878</b> <b>Dec. 31, 1887</b>
9. AGE (In years last birthday) <b>80</b> <b>78</b> yrs		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>18</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Minn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry DeWitz</b>		14. MOTHER'S MAIDEN NAME <b>Hennerita Krigmier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, Metastatic of liver</b> DUE TO (b) <b>Carcinoma of Colon</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 Months</b> <b>7/24/59</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-20-59</b> to <b>9-19-59</b> , that I last saw the deceased alive on <b>9-15-59</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3701 Conover Rd. Bethesda, Md.</b> DATE SIGNED <b>9-19-59</b> ACTUAL SIGNATURE <b>C. Roger Kurtz, M.D.</b> PHYSICIAN'S NAME (Type) <b>C. Roger Kurtz, M.D. Washington, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>9-23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 24 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles A. K...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



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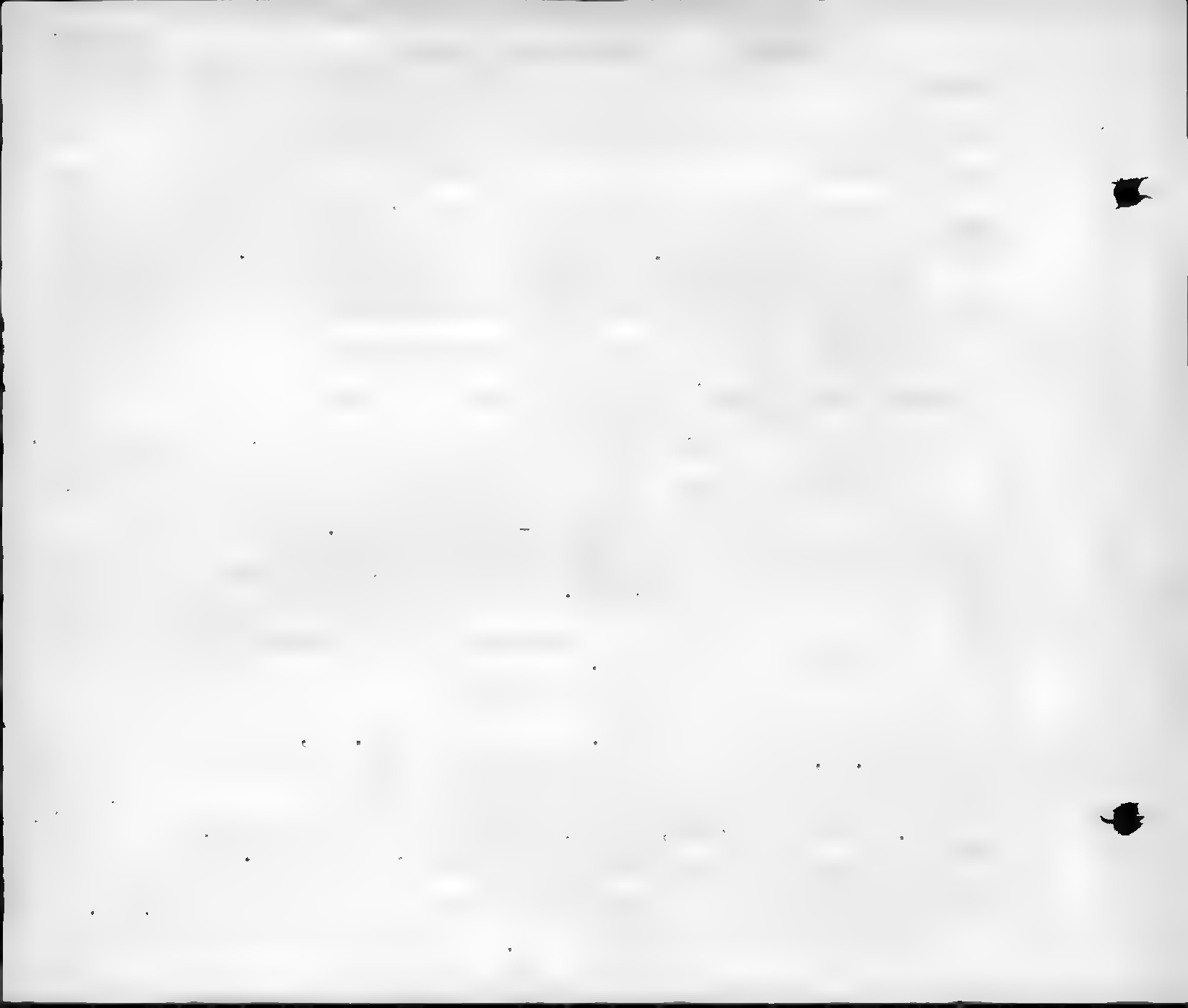
CERTIFICATE OF DEATH

Reg. Dist. No. 10332

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Browningsville</u>				c. LENGTH OF STAY IN 1b <u>X</u> Rural- <u>Lewisdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. Monrovia</u>				d. STREET ADDRESS <u>R.F.D. Clarksburg</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Barry</u> Middle <u>R.</u> Last <u>Beall</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1886</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dairy Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Lewisdale, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Cronin Beall</u>				14. MOTHER'S MAIDEN NAME <u>Sally Lawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>215-36-7380</u>		17. INFORMANT <u>Miss Esther W. Beall, Clarksburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Occlusion</u> DUE TO Cardio-vascular-renal disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO Previous arterial thrombi, as retinal artery, etc. (c) <u>15 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No injury.</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> 19 <u>35</u> , to <u>Sept. 10, 1959</u> , that I last saw the deceased alive on <u>Sept. 9, 1959</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Druid Theatre Building, Damascus, Maryland.</u> <u>9/11/59</u>							
ACTUAL SIGNATURE <u>M. McKendree Boyer, M.D.</u>				PHYSICIAN'S NAME (Type) <u>M. McKendree Boyer, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Browningsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mobaworth</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Richard S. Fugate</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10333

10343

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>908 Davis Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>BARNES</u> Last <u>BEAM</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11, 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Substation man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Beam</u>				14. MOTHER'S MAIDEN NAME <u>Alverda W.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-03-9208</u>		17. INFORMANT <u>Mrs. Lucy P. Beam, (same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Liver metastases</u>							
156.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 1, 1959</u> to <u>5 Sept</u> , 1959, that I last saw the deceased alive on <u>4 Sept</u> , 1959, and that death occurred at <u>1:00 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. B. Queen</u>				ADDRESS (Street, city or town, state) <u>7112 Willow Ave</u>			
PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>				DATE SIGNED <u>5 Sept 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>Sept. 8, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Prince George County, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				ADDRESS <u>254 Carroll M Rd DE</u>		24a. REC'D BY REGISTRAR <u>SEP 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





10384

## CERTIFICATE OF DEATH

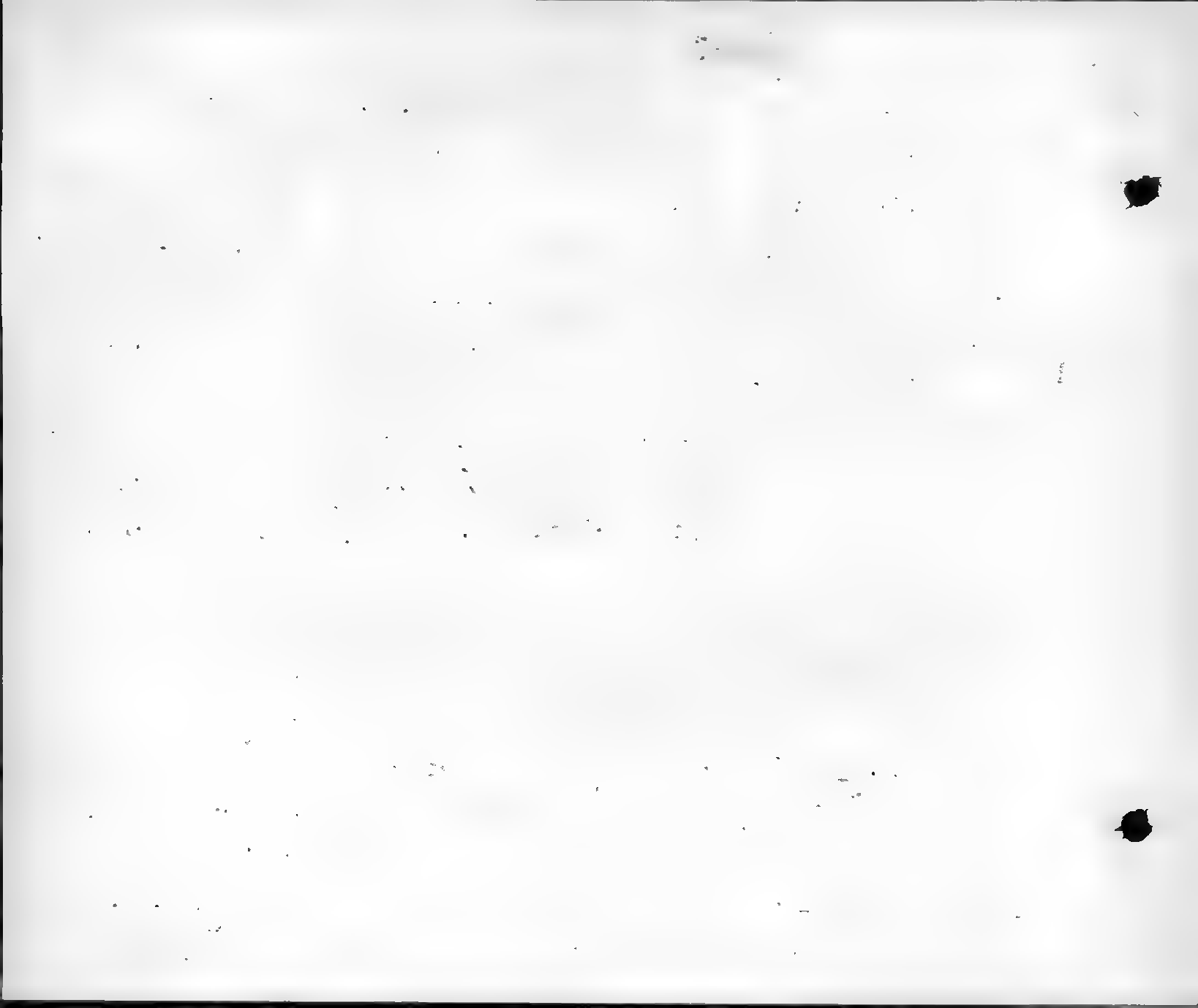
Reg. Dist. No.

10334

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4702 Highland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RUFUS</b> Middle <b>C.</b> Last <b>BEAVERS</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.	11. IF UNDER 24 HRS Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chestnut Farms Dairy</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Thomas Beavers</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-03-6506</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same as Item #2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>420.0</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>10 YRS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 HR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 25</b> , 19 <b>59</b> , to <b>Sept 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 25</b> , 19 <b>59</b> , and that death occurred at <b>12:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo I. Donovan</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>8016 Old Georgetown Rd. Bethesda, Md. 9-26-59</b>	
PHYSICIAN'S NAME (Type) <b>LEO I. DONOVAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-29-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kenna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

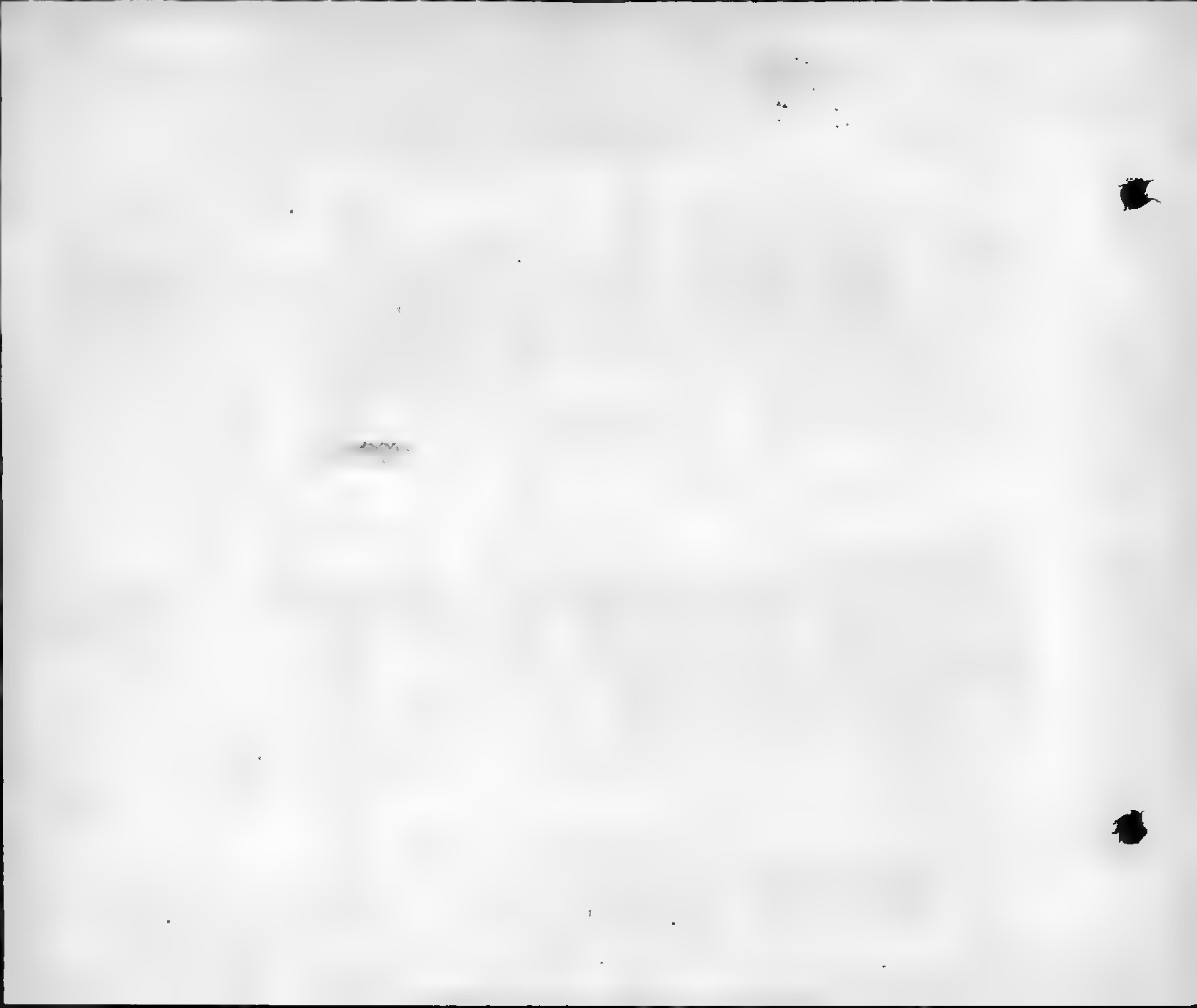
10335

Reg. Dist. No.

10385

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mass</b> b. COUNTY <b>Hampden</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>8 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westfield</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>(Trailer truck) Hamden Lane</b>				d. STREET ADDRESS <b>11 Palmer Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Honore</b> Middle <b>J</b> Last <b>Begin</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>4</b> Year <b>19 59</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 24, 1898</b>		
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>10</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>paper-maker</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>yes-unknown</b>		17. INFORMANT <b>Alvah Buckmore son-in-law</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4d0.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>FRANK J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>9-4-59</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>9/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westfield, Mass.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>		
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

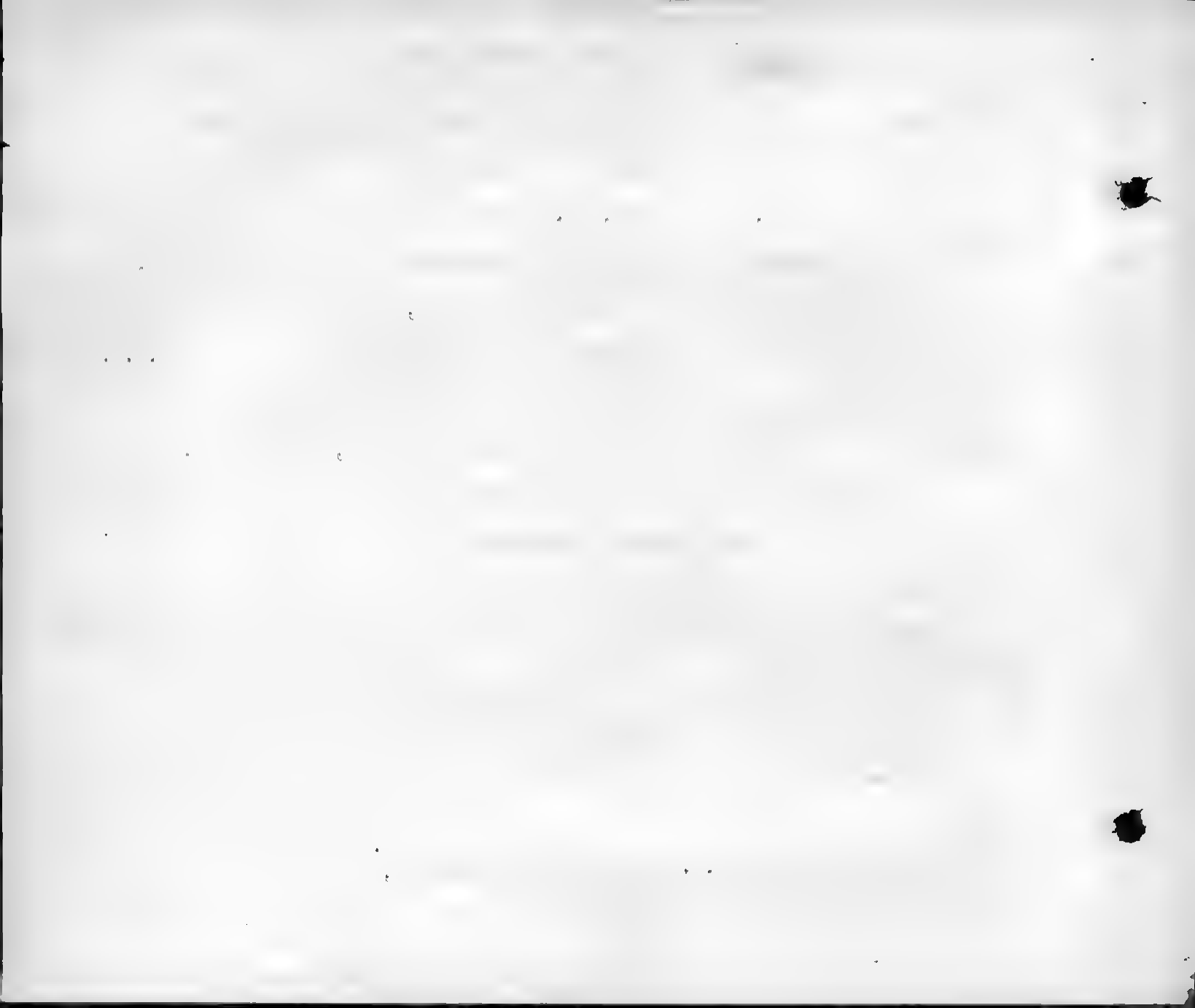
10386

## CERTIFICATE OF DEATH

10336

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		d. STREET ADDRESS <b>5209 Chandler Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Delbert</b> Middle <b>Mauritz</b> Last <b>Bergenstal</b>			<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>12</b> Year <b>19 59</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>December 23, 1917</b>	
<b>9. AGE</b> (In years last birthday) <b>41 yrs</b>		<b>IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Physician</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Government</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Missouri</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Carl Bergenstal</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Stena Jensen</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO</b> <b>Unavailable</b>		<b>17. INFORMANT</b> <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocarditis due to Hypokalemia</b> DUE TO (b) <b>Post Necrotic Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Uremia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Staphylococcal Pyelonephritis</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>2½ Years</b> <b>2 days</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>September 1, 19 59</b> , <b>to</b> <b>September 12, 19 59</b> , <b>that I last saw the deceased alive on</b> <b>September 12, 19 59</b> , <b>and that death occurred at</b> <b>10:30 P. M.</b> , <b>from the causes and on the date stated above</b> <b>ADDRESS</b> (Street, city or town, state) <b>The Clinical Center</b> <b>DATE SIGNED</b> <b>9/13/59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
<b>ACTUAL SIGNATURE</b> <i>John P. Utz</i> <b>M.D.</b>				<b>PHYSICIAN'S NAME (Type)</b> <b>JOHN P. UTZ, M.D.</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>9/16/59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Arlington, Virginia</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b>				<b>ADDRESS</b> <b>Bethesda, Maryland</b>		<b>24b. REC'D BY REGISTRAR</b> <b>DATE SEP 15 '59</b>	
<b>24c. REGISTRAR'S SIGNATURE</b> <i>Arthur E. Evans</i>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

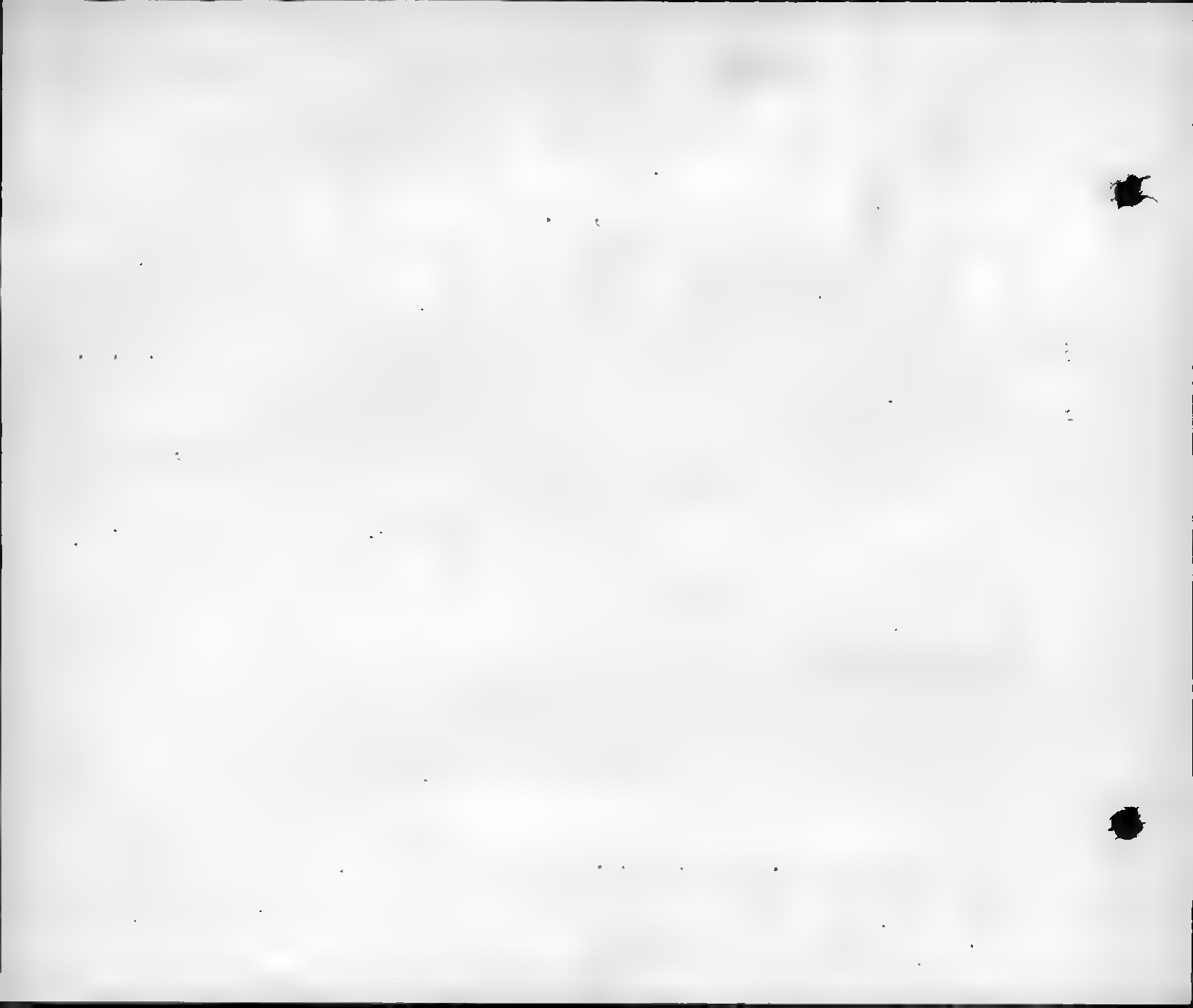
10337

10387

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>32 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>New Martinsville</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Northgate Drive</b> d. STREET ADDRESS <b>Northgate Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lisa</b> Middle <b>Jane</b> Last <b>Blair</b>				4. DATE OF DEATH Month <b>September</b> Day <b>1</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 12, 1954</b>	
9. AGE (In years last birthday) <b>5</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13. FATHER'S NAME <b>Perry D. Blair</b>		14. MOTHER'S MAIDEN NAME <b>Glenna Wagner</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Hemorrhages</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Leukemia with Pancytopenia</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Septicemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 Months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 31</b> , 19 <b>59</b> , to <b>September 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>September 1</b> , 19 <b>59</b> , and that death occurred at <b>11:00 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>9/2/59</b>							
ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b>		M.D. <b>The Clinical Center</b>		NATIONAL INSTITUTES OF HEALTH <b>Bethesda 14, Maryland</b>		PHYSICIAN'S NAME (Type) <b>LAWRENCE A. GAYDOS, M.D.</b>	
22a. RIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>9-2-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>NEW MARTINSVILLE, VA</b>		22d. LOCATION (City, town or county) (State) <b>WEST</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D.W. Chambers</b>		ADDRESS <b>1400 Chapin St NW, Wash, D.C.</b>		24a. REC'D BY REGISTRAR <b>SEP 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneel</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10344

## CERTIFICATE OF DEATH

10338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakima Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakima Park</u>			
c. LENGTH OF STAY IN 1b <u>49 days</u>				d. STREET ADDRESS <u>1402 Tulip Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE E. (MRS) BLANKS</u>				4. DATE OF DEATH Month Day Year <u>Sept. 15 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-8-1863</u>	
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jesse Ridgeway</u>				14. MOTHER'S MAIDEN NAME <u>Mary Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO <u>471X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/12</u> , 19 <u>47</u> , to <u>9/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/15</u> , 19 <u>59</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Dean H. Harding</u> M.D. <u>1130 1st St. N.W. Wash D.C. 9/15/59</u>							
PHYSICIAN'S NAME (Type) <u>DEAN H. HARDING</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 19, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St. NW</u>				24a. REC'D BY REGISTRAR <u>SEP 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



10388

# CERTIFICATE OF DEATH

Reg. Dist. No.

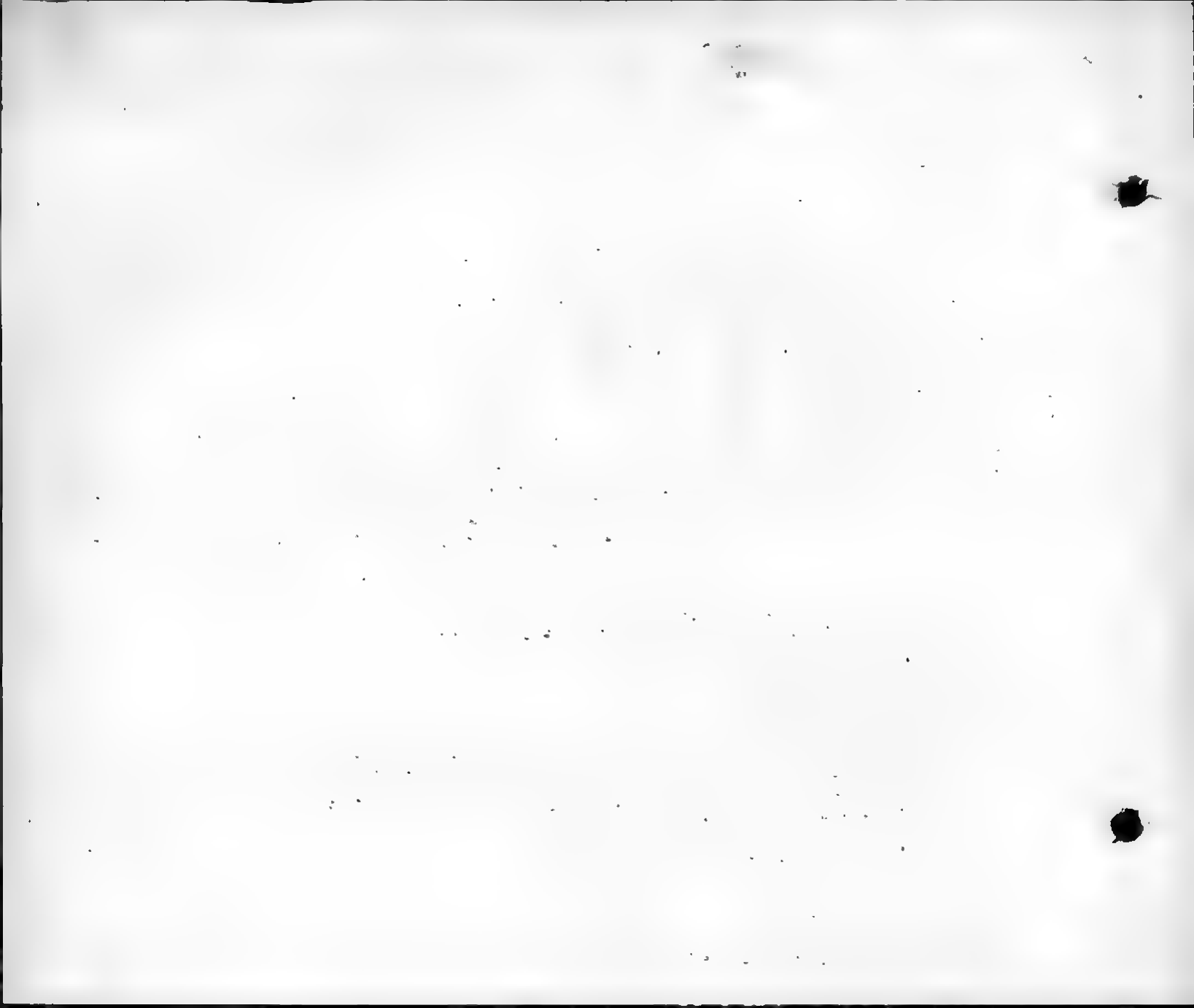
10339

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			c. LENGTH OF STAY IN 1b <u>14 hrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>15102 WESSLING LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>JOHN</u> Middle <u>HERBERT</u> Last <u>BOLAN</u>		4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1876</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 MRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD STA. AGENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>ICWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN BOLAN</u>				14. MOTHER'S MAIDEN NAME <u>BLESSINGTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>		INFORMANT <u>Mrs. W. G. HOLDEN</u>		Address <u>5102 Wessling LA -</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/7</u> , 19 <u>58</u> to <u>Sept 1</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Sept 2</u> , 19 <u>59</u> , and that death occurred at <u>12 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4890 Battery Lane, Bethesda, Md</u> DATE SIGNED <u>9/4/59</u>							
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantrant</u> M.D.		PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantrant</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Bur. Trans.</u>		<u>9-3-59</u>		<u>Scranton Cemetery</u>		<u>Scranton, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>SEP 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



## CERTIFICATE OF DEATH

10340

Reg. Dist. No.

10345

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>5 1/2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Elis</u> Last <u>Bowers</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30-10</u>	9. AGE (In years last birthday) <u>54</u> yrs	IF UNDER 1 YEAR Months <u>0000</u> Days <u>0000</u>	IF UNDER 24 HRS Hours <u>0000</u> Min. <u>0000</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spec. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FBI</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James R. Bowers, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Winifred HUTCHESON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT <u>Washington Sanatorium &amp; Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Coronary Artery Disease</u> DUE TO (c) <u>Undetermined</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m., p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Sept 16, 1959</u> to <u>Sept 20, 1959</u> that I last saw the deceased alive on <u>Sept 20, 1959</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>George L. Ball</u> M.D.				ADDRESS (Street, city or town, state) <u>10620 Georgia Ave Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>				DATE SIGNED <u>SEP 21 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WASH. NAT'L. CEMETERY</u>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Warner</u> <u>WARNER E. PUMPHREY</u>			24a. REC'D BY REGISTRAR <u>SEP 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





10389

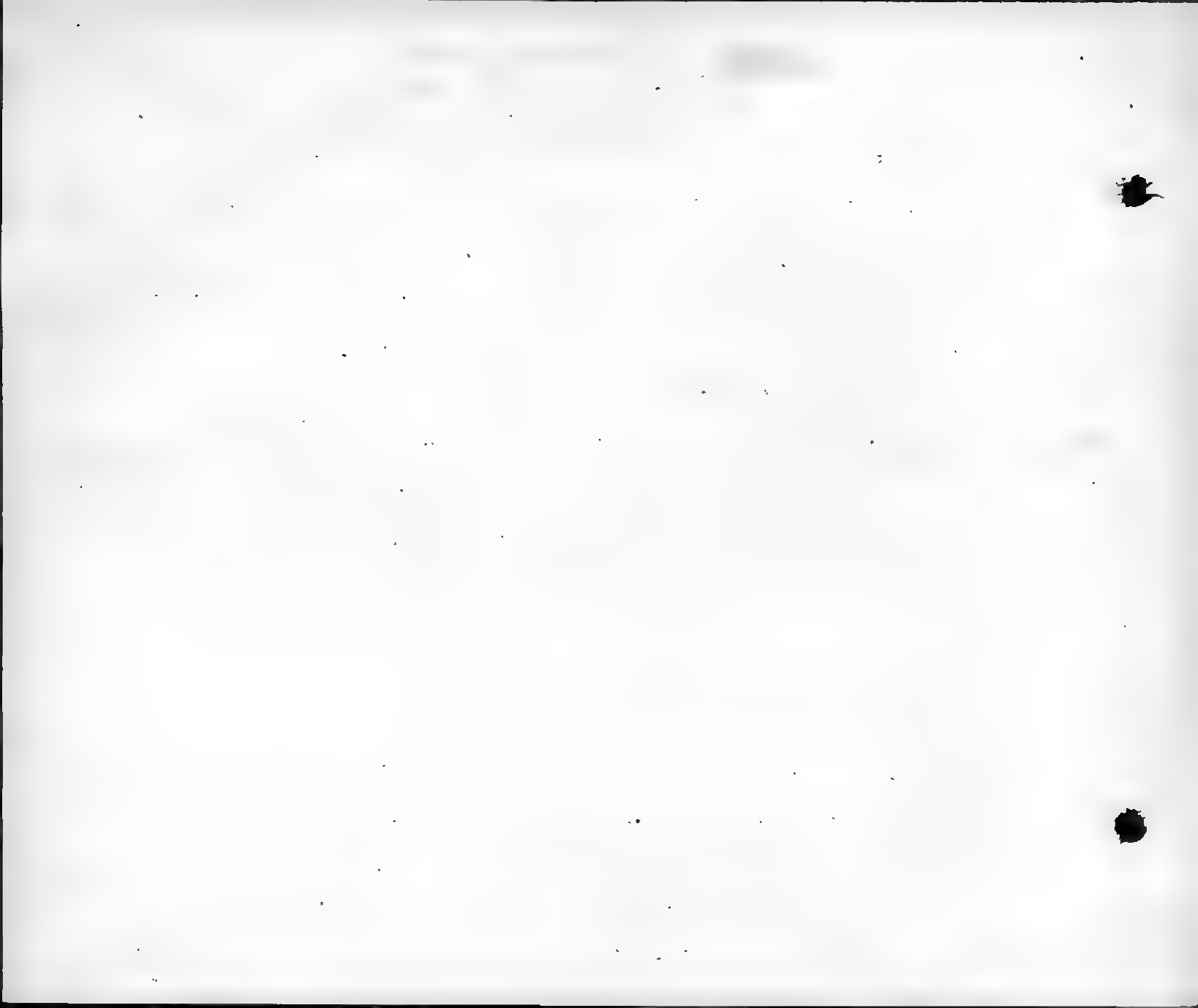
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ORTHESDA</u>		c. LENGTH OF STAY IN 1b <u>15 HRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHLBY CHASE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>14605 HUNT AVENUE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>AGEE</u> Last <u>BOWLES</u>				4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1 1881</u>		9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>XXXXXXXXX William Bowles</u>				14. MOTHER'S MAIDEN NAME <u>Signora Agee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>YES</u>		INFORMANT (WIFE) Address <u>MARJORIE H. BOWLES</u> <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> DUE TO Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>CARCINOMA</u> <u>STOMACH</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> <u>3 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> to <u>July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>59</u> , and that death occurred at <u>12 M.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo I Donovian MD</u> M.D. <u>8016</u>				ADDRESS (Street, city or town, state) <u>Bethesda, Maryland</u> DATE SIGNED <u>9/17/59</u>			
PHYSICIAN'S NAME (Type) <u>LEO I DONOVAN MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino J. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



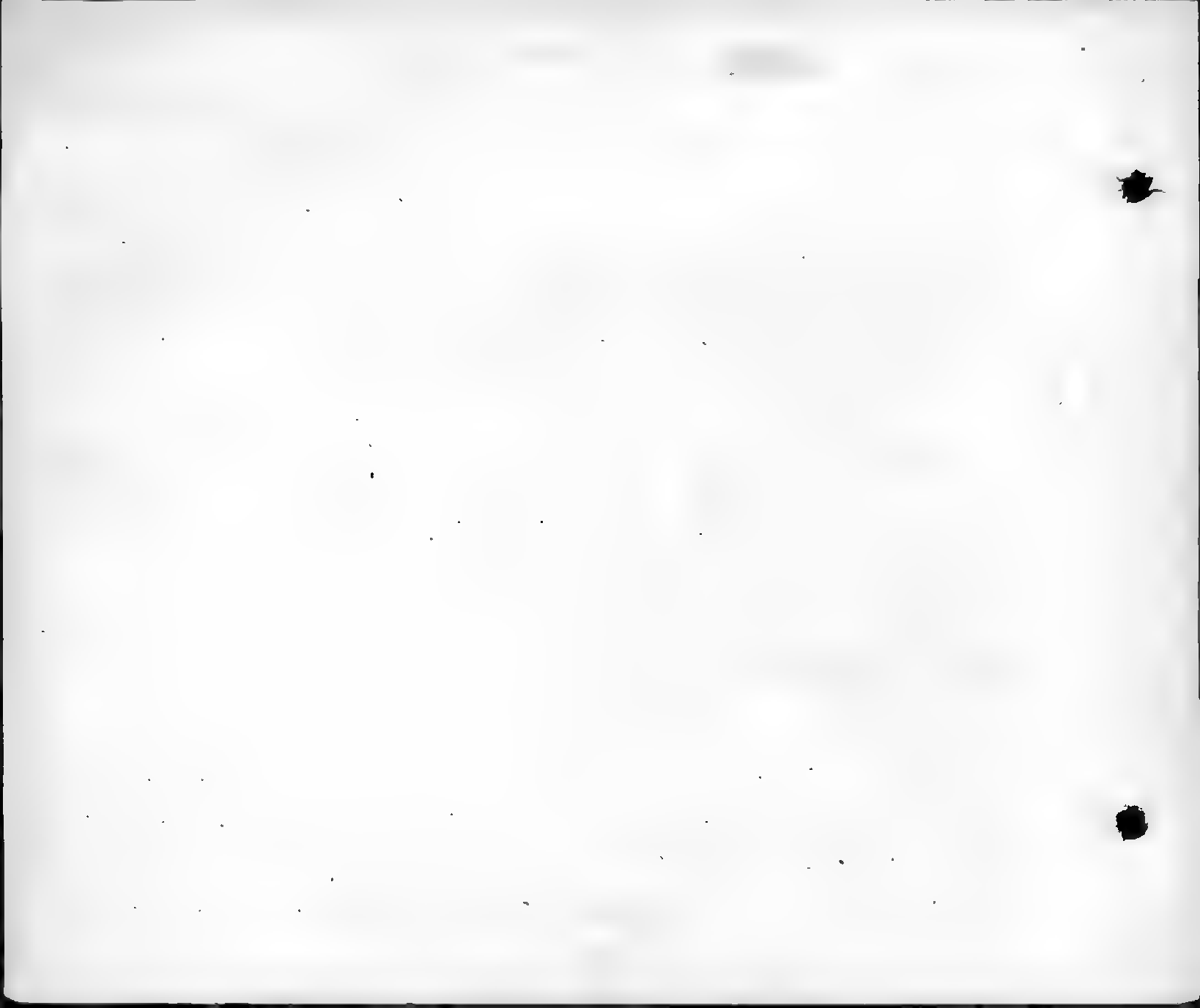
10390

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEITCHSDALE</u>		c. LENGTH OF STAY IN 1b <u>544 2 MRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VENNE LUKA LASHAW</u>		4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>5</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home making</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEONARD ?</u>		14. MOTHER'S MAIDEN NAME <u>LUCY MARLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
INFORMANT <u>(HUSBAND)</u> <u>GERALD L. DRAWSHAW</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recent Posterior Myocardial Infarction</u> 4. DUE TO <u>Coronary Thromboses</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>2 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 28</u> , 1959, to <u>Sept 29</u> , 1959, that I last saw the deceased alive on <u>Sept 29</u> , 1959, and that death occurred at <u>BA</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>10511 Summit Ave Kensington, Md</u> DATE SIGNED <u>9/29/59</u>			
ACTUAL SIGNATURE <u>George Sharpe M.D.</u>		PHYSICIAN'S NAME (Type) <u>GEORGE SHARPE</u>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton J. Hamrick</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10346

## CERTIFICATE OF DEATH

Reg. Dist. No.

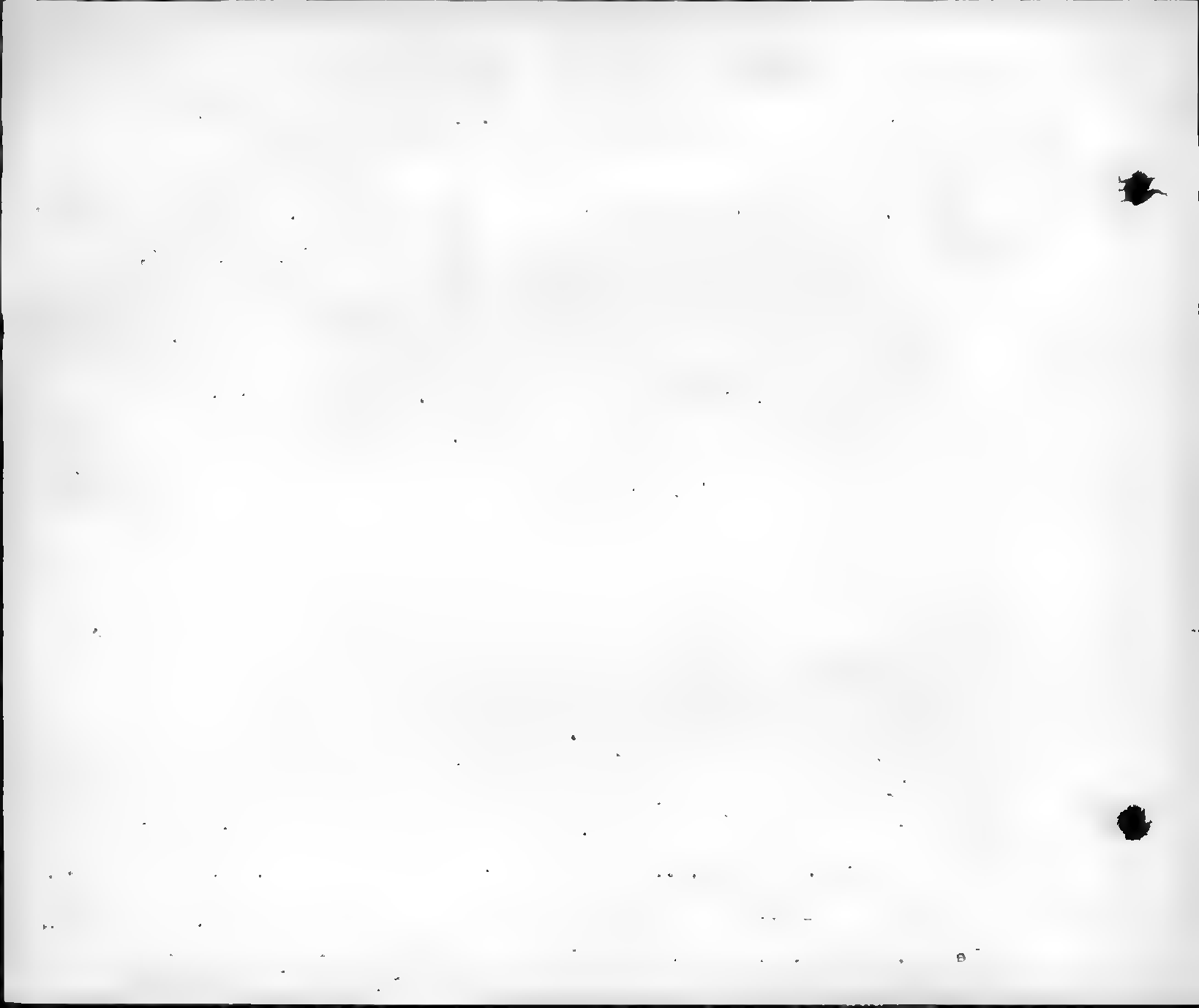
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b> c. LENGTH OF STAY IN 1b <b>Washington Sanitarium and Hospital</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b> d. STREET ADDRESS <b>3926 Isbell St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Brammer</b>		4. DATE OF DEATH Month Day Year <b>September 23, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 19, 1959</b>
9. AGE (In years last birthday) <b>4</b>		10. IF UNDER 1 YEAR: Months Days Hours Min. <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>no</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>James Duro Brammer</b>		14. MOTHER'S MAIDEN NAME <b>Faith Elaine Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>father</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abletase</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 19, 1959</b> to <b>Sept 22, 1959</b> that I last saw the deceased alive on <b>Sept 21, 1959</b> and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Ernest A. Sarao, M.D.</b> <b>7006 New Hampshire Ave., Takoma Park, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			
22b. DATE THEREOF <b>9-24-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital, Takoma Park 12, Md.</b>	
22d. LOCATION (City, town, or county) (State) <b>Takoma Park 12, Md.</b>		22e. REC'D BY REGISTRAR <b>Robert A. Hare, M. D.</b>	
22f. REGISTRAR'S SIGNATURE <b>Robert A. Hare, M. D.</b>		22g. DATE <b>Oct 1 1959</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075433XU3

OCT 1 1959

Ernest A. Sarao



## CERTIFICATE OF DEATH

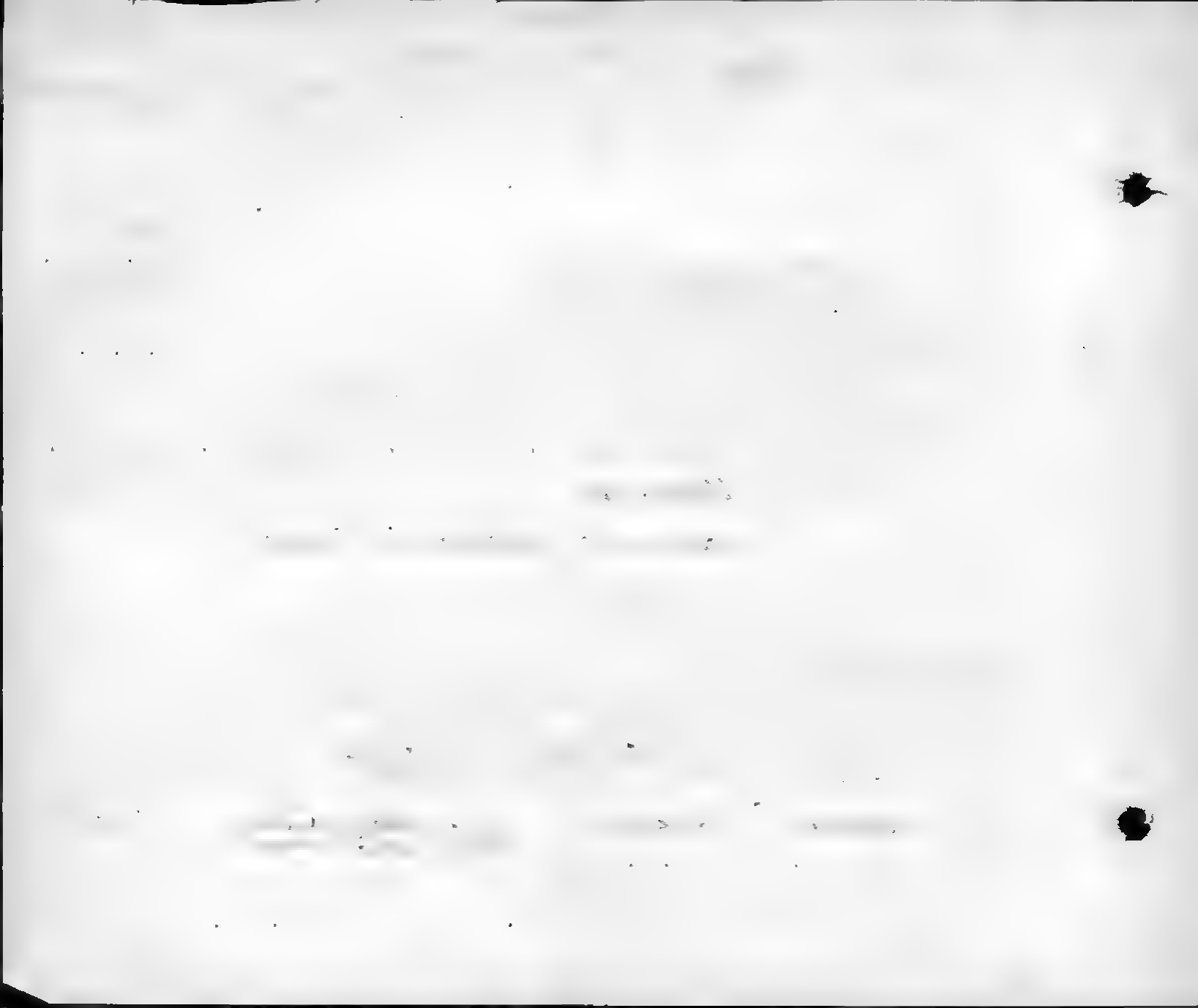
10391

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>12 years</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS <u>formerly of: 697 Gladstone Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Lee</u> Last <u>Broughton</u>		4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>	8. DATE OF BIRTH <u>June 22, 1861</u>
9. AGE (In years last birthday) <u>98</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Broughton</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Ann <del>Green</del> Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Mr. Clarence H. Green - 5220 N. Fairfax Ave.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer c metastasizing to ureters.</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-22</u> 19 <u>59</u> , to <u>9-26</u> 19 <u>59</u> , that I last saw the deceased alive on <u>9-25</u> 19 <u>59</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah E. Glover</u> M.D.		ADDRESS (Street, city or town, state) <u>10128 Cedar Lane Kensington, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Sarah E. Glover, M. D.</u>		DATE SIGNED <u>9-26-59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/29/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William F. Tucker</u> ADDRESS <u>1601 17th St</u>		24a. REC'D BY REGISTRAR <u>SEP 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur D. Hume</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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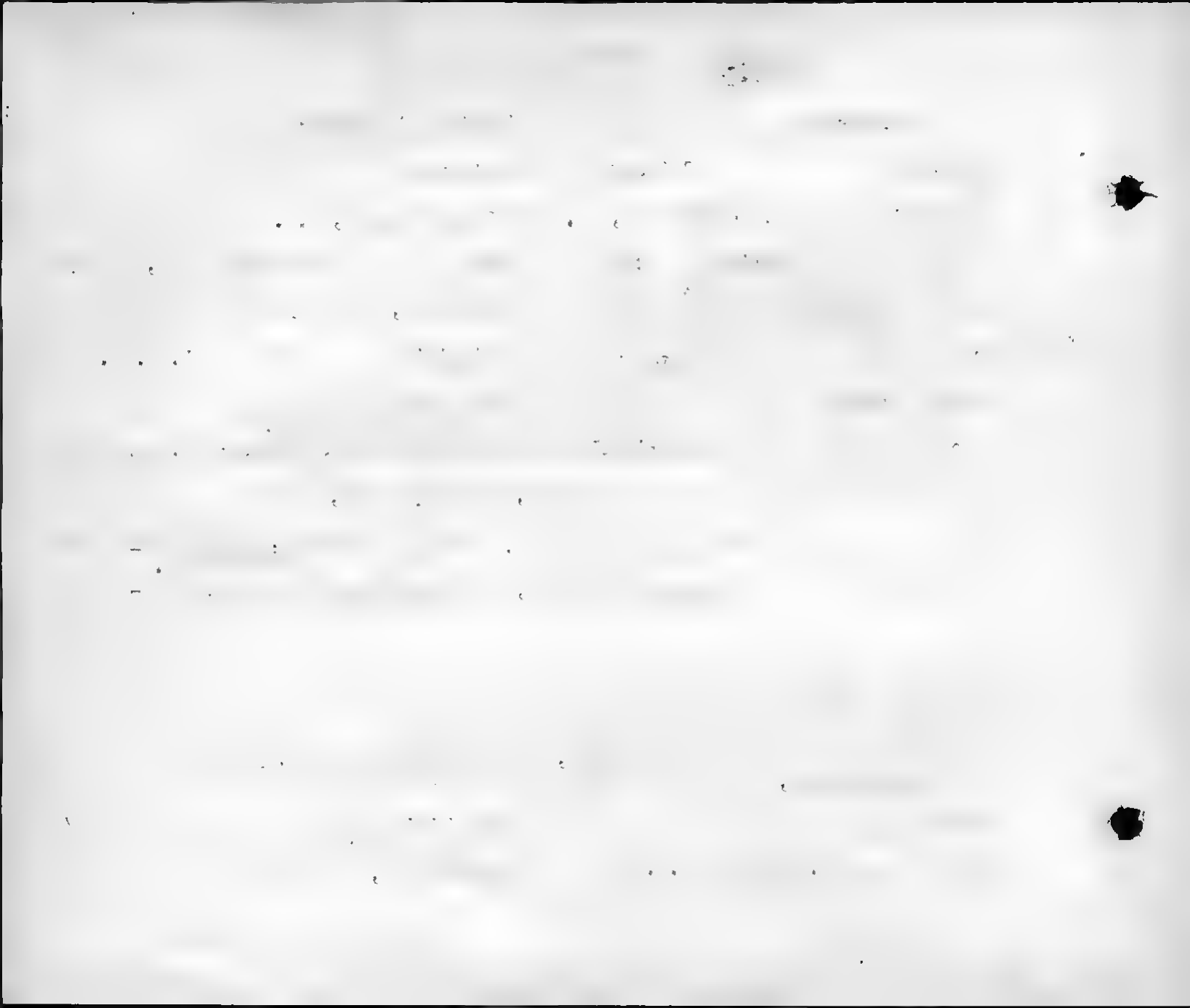
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10392

## CERTIFICATE OF DEATH

Reg. Dist. No. 10345

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>112 days</b>		d. STREET ADDRESS <b>5911 Dick Street, N.E.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Beadie Lee Brown</b>		4. DATE OF DEATH <b>September 29, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 19, 1903</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR: Months <b>29</b> Days <b>19</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert Watson</b>		14. MOTHER'S MAIDEN NAME <b>Alice Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record,</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure, Pulmonary Edema, Acute</b> DUE TO <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Metastatic Carcinoma, Pulmonary &amp; Anemia; Uremia</b> DUE TO <b>Obstruction.</b> (c) <b>Carcinoma of Cervix, Uteri and Bilateral Uteral</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 Minutes</b> <b>3-5 Weeks</b> <b>6-8 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 9, 1959</b> to <b>September 29, 1959</b> , that I last saw the deceased alive on <b>September 29, 1959</b> , and that death occurred at <b>12:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center Bethesda 14, Maryland</b> DATE SIGNED <b>9/30/59</b>			
ACTUAL SIGNATURE <b>Alan B. Retik</b>		PHYSICIAN'S NAME (Type) <b>ALAN B. RETIK, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>10-3-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frazier's Funeral Home, 389-R.D. Ave. NW</b>		24a. REC'D BY REGISTRAR <b>DATE 2-59</b>	
24b. REGISTRAR'S SIGNATURE			



10393

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Summit Point</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN 1b <b>1 Y</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home for the Aged, Inc.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GERTRUDE</b>		First Middle Last <b>BROWN</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 12-1871</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>4</b>	IF UNDER 24 HRS Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>Jefferson Co., West Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Brotherton</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Spotts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Asbury Methodist Home</b> Address <b>Gaithersburg</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>hypertensive cardiovascular disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-8</b> , 19 <b>58</b> , to <b>9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 16</b> , 19 <b>59</b> , and that death occurred at <b>1:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10128 CEDAR LAVE NENNING TOW, MD</b> DATE SIGNED <b>9-16-59</b>							
ACTUAL SIGNATURE <b>Sarah E. Glover</b>		M.D. <b>10128 CEDAR LAVE NENNING TOW, MD</b>					
PHYSICIAN'S NAME (Type) <b>Sarah E. Glover, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Berryville Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gastner</b>				ADDRESS <b>Gaithersburg Md</b>		24a. REC'D BY REGISTRAR <b>SEP 18 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur A. Prand</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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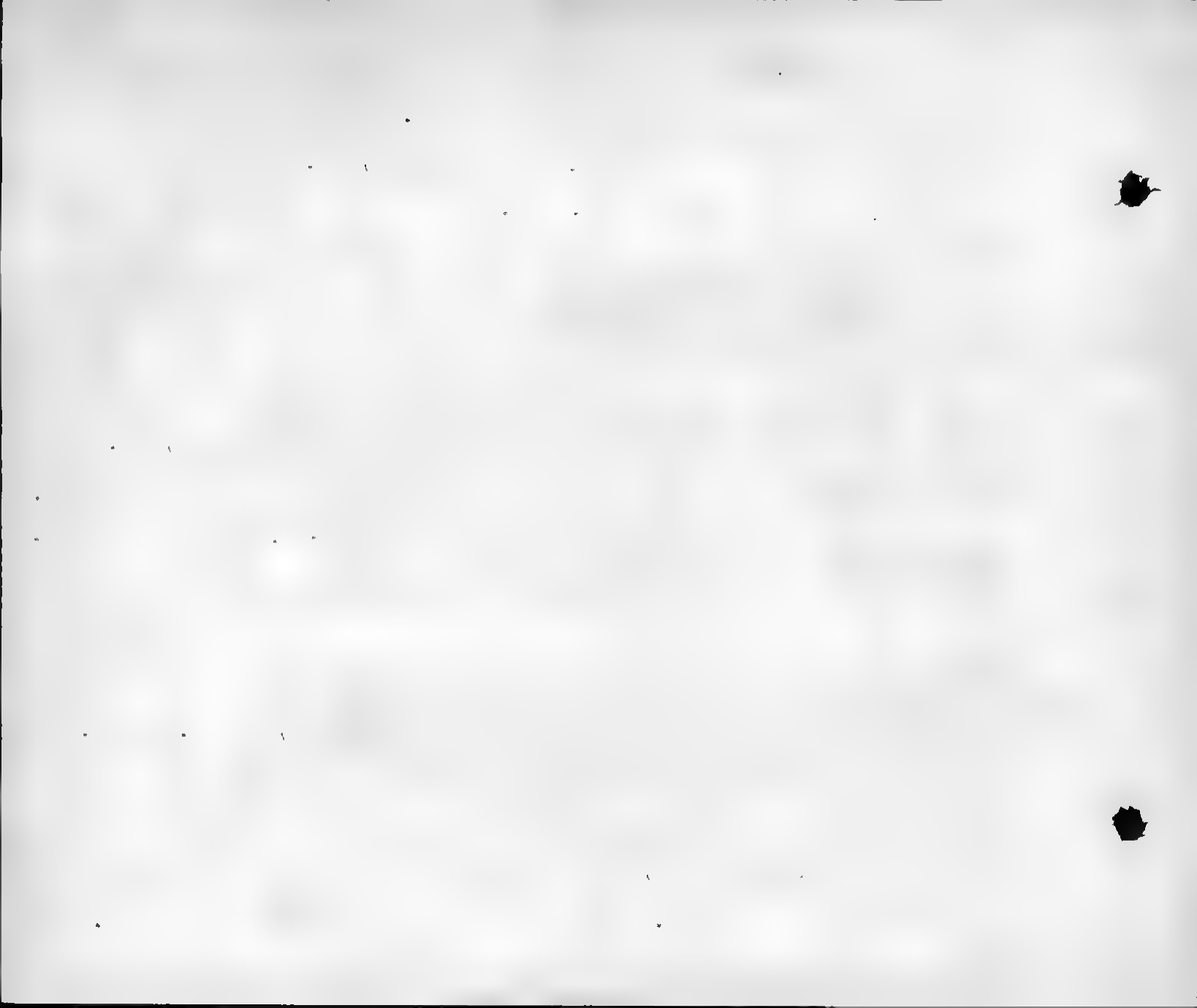
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 10347									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brinklow/ Olney</b>			c. LENGTH OF STAY IN 1b <b>33 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brinklow, Rt. 116</b>			d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery County General Hosp. Inc.</b>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Leroy</b> Last <b>Brown</b>					4. DATE OF DEATH Month <b>September</b> Day <b>18</b> Year <b>19 59</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/11/99</b>		9. AGE (in years last birthday) <b>60 yrs.</b>	
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscapist</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Brown</b>					14. MOTHER'S MAIDEN NAME <b>Maude Johnson</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Olney, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>33 hrs.</b> <b>812x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Inter-capsular hemorrhage-lt.kidney</b> <b>33 hrs.</b> (c) <b>Inter-capsular hemorrhage-lt.kidney</b> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of pelvis</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Truck backed over him while attempting to close a gate</b>									
20c. TIME OF INJURY Month, Day, Year Hour <b>XX</b> P. M. <b>3:15</b> <b>9/16</b> <b>19 59</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) <b>Unity, Montg.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <b>9/18/59</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 21</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) <b>Highland</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clayton Barker</b> ADDRESS <b>Laytonsville, Md</b>					24a. REC'D BY REGISTRAR DATE <b>SEP 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

MEDICAL CERTIFICATION



10395

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney, Md.</b>		c. LENGTH OF STAY IN 1b <b>48 Hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Katie</b> Middle <b>Duncan</b> Last <b>Buckley</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/8/78</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR: Months <b>1</b> Days <b>17</b> Hours <b>42</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elzie Duncan Shackelford</b>		14. MOTHER'S MAIDEN NAME <b>Annie Mae Balthrope</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema acute</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis - Myocardial</b> DUE TO <b>Infarction + auricular Fibrillation</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>48 hrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 Sept</b> , 19 <b>59</b> , to <b>24 Sept</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>24 Sept</b> , 19 <b>59</b> , and that death occurred at <b>1 A.</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John Bosley Ziegler</b> M.D.		ADDRESS (Street, city or town, state) <b>Olney, Md.</b>	
PHYSICIAN'S NAME (Type) <b>JOHN BOSLEY ZIEGLER</b>		DATE SIGNED <b>24 Sept 59</b>	
22a. BURIAL, CREMATION, RESURGEANCE (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Montgomery Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>May W. Barber</b> ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4-0

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

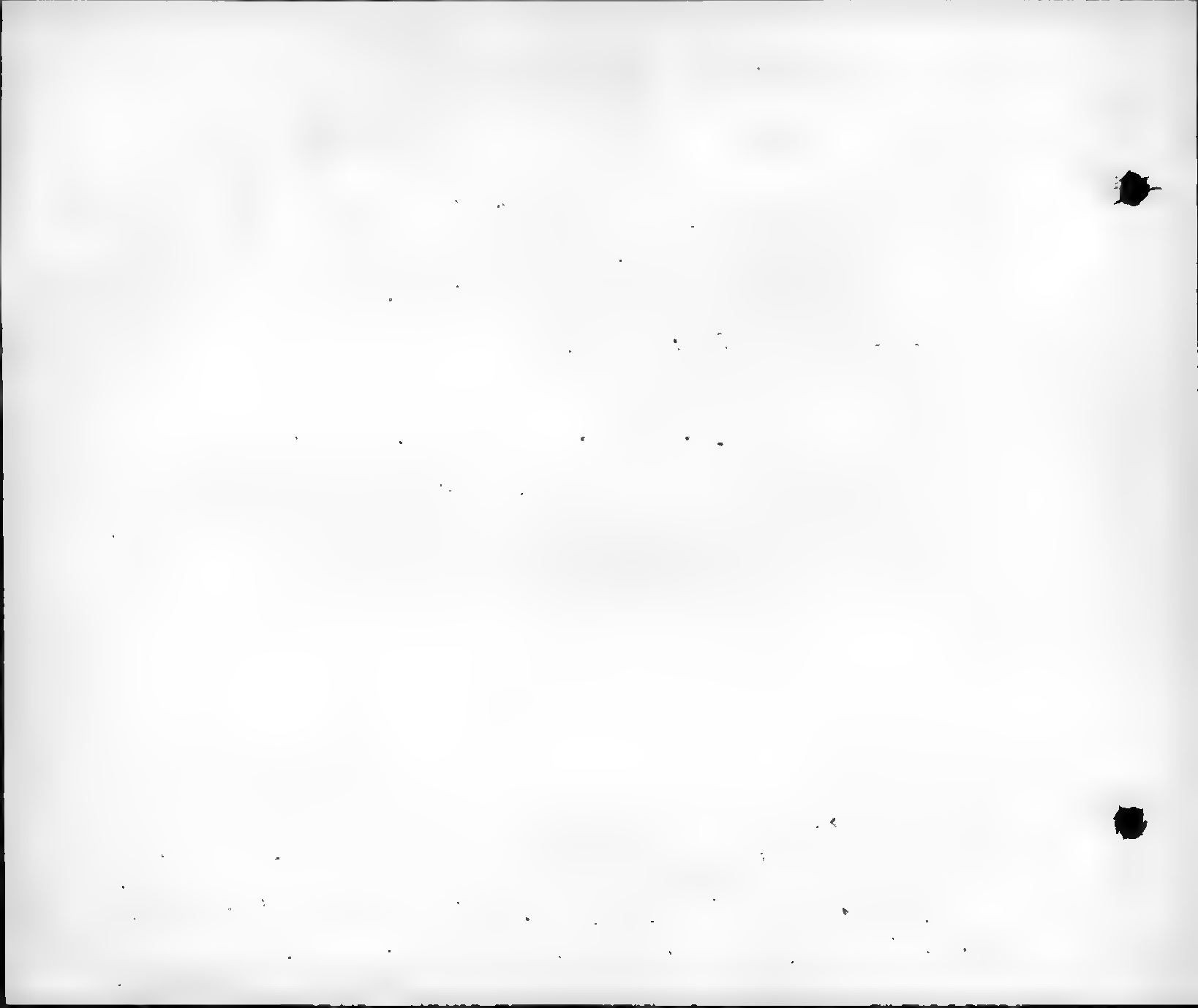
10347

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hosp</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Rural</u>	
f. STREET ADDRESS <u>Box 507 Metzerott Rd</u>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Albert Burdis</u>		4. DATE OF DEATH Month Day Year <u>9 27 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/1900</u>
9. AGE (In years last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN BLDG TRADES.</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph A Burdis, sr.</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>579-03-9370</u>	
INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Heart Block - complete</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>7 yrs</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 26, 1959</u> , to <u>Sept 27, 1959</u> , that I last saw the deceased alive on <u>Sept 27, 1959</u> , and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Tak. Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>		DATE SIGNED <u>9/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 28, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Washington Gen. Riggs Rd. Hyattsville, Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Hays</u> ADDRESS <u>254 Carroll St. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>Sept 27, 1959</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur H. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 29 59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

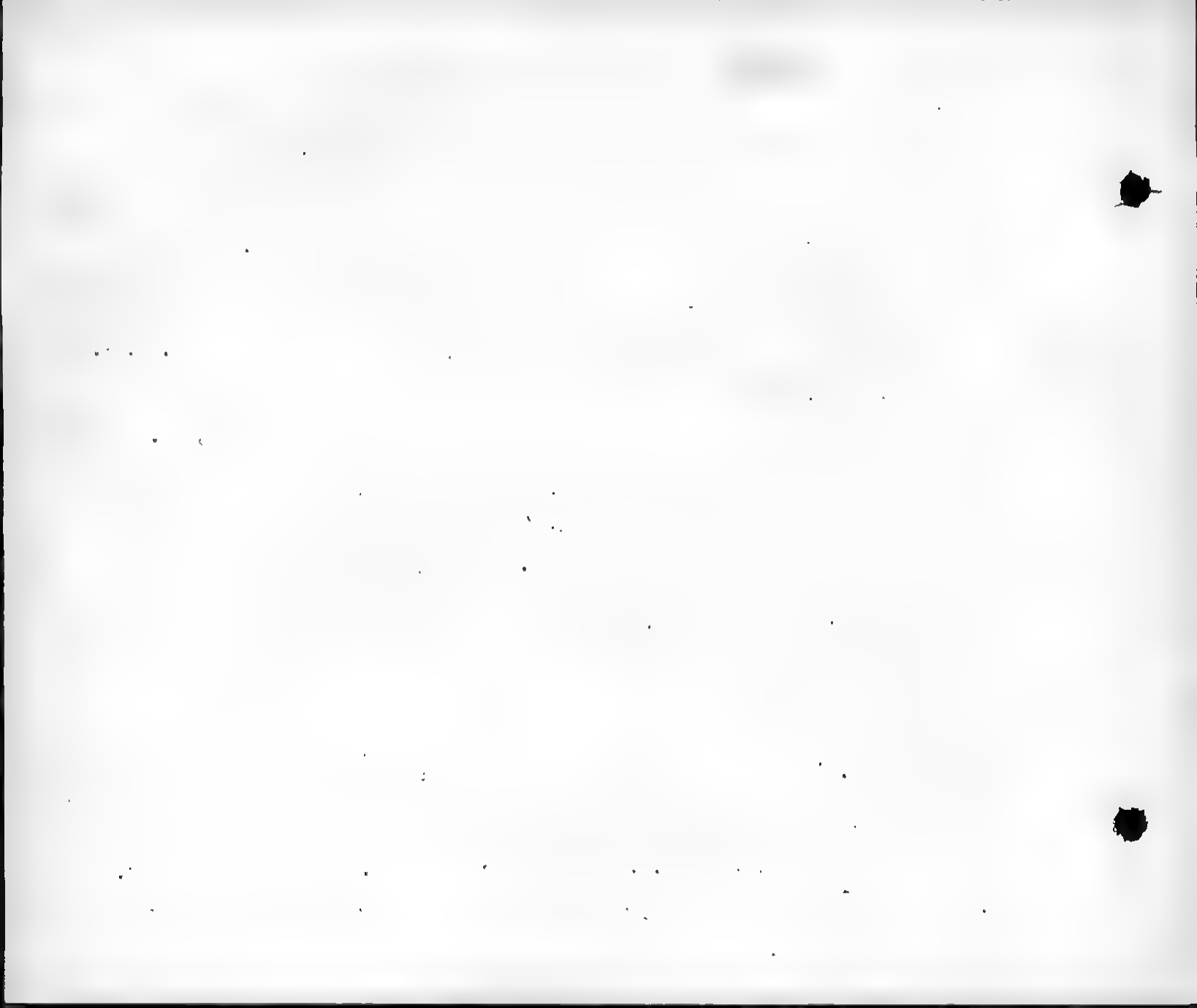
## CERTIFICATE OF DEATH

Reg. Dist. No.

10350

10396

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairland (Rural)</b> c. LENGTH OF STAY IN 1b <b>75 yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Fairland (Rural)</b> d. STREET ADDRESS <b>/</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Katie</b> Middle <b>Burton</b> Last <b>Burton</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 6 1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>George Jackson</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Jackson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service	
16. SOCIAL SECURITY NO.		INFORMANT <b>Dora Williams Silver Spring, Md. Route 2</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremic Coma. Dissecting Aneurysm.</b> <b>411 X</b> DUE TO <b>Hemiplegia (old) Cardiorenal Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO <b>Arteriosclerosis Hypertension.</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis Fibroid Tumor Uterus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days 7 30</b>	
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 20</b> 19 <b>30</b> , to <b>Sept. 4</b> 19 <b>59</b> that I last saw the deceased alive on <b>Sept. 4</b> 19 <b>59</b> , and that death occurred at <b>12:15 P.M.</b> From the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Norbeck, Rt. 1 Silver Spring, Md.</b> DATE SIGNED <b>98.59</b> ACTUAL SIGNATURE <b>Webster Sewell</b> M.D. PHYSICIAN'S NAME (Type) <b>Webster Sewell, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>LUKIAH</b>		22b. DATE THEREOF <b>9-8-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROUND OAK</b>		22d. LOCATION (City, town, or county) (State) <b>Spencerville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Suonden</b>		ADDRESS <b>Rockville, Md.</b>	
24a. RECEIVED BY REGISTRAR <b>SEPT 10 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

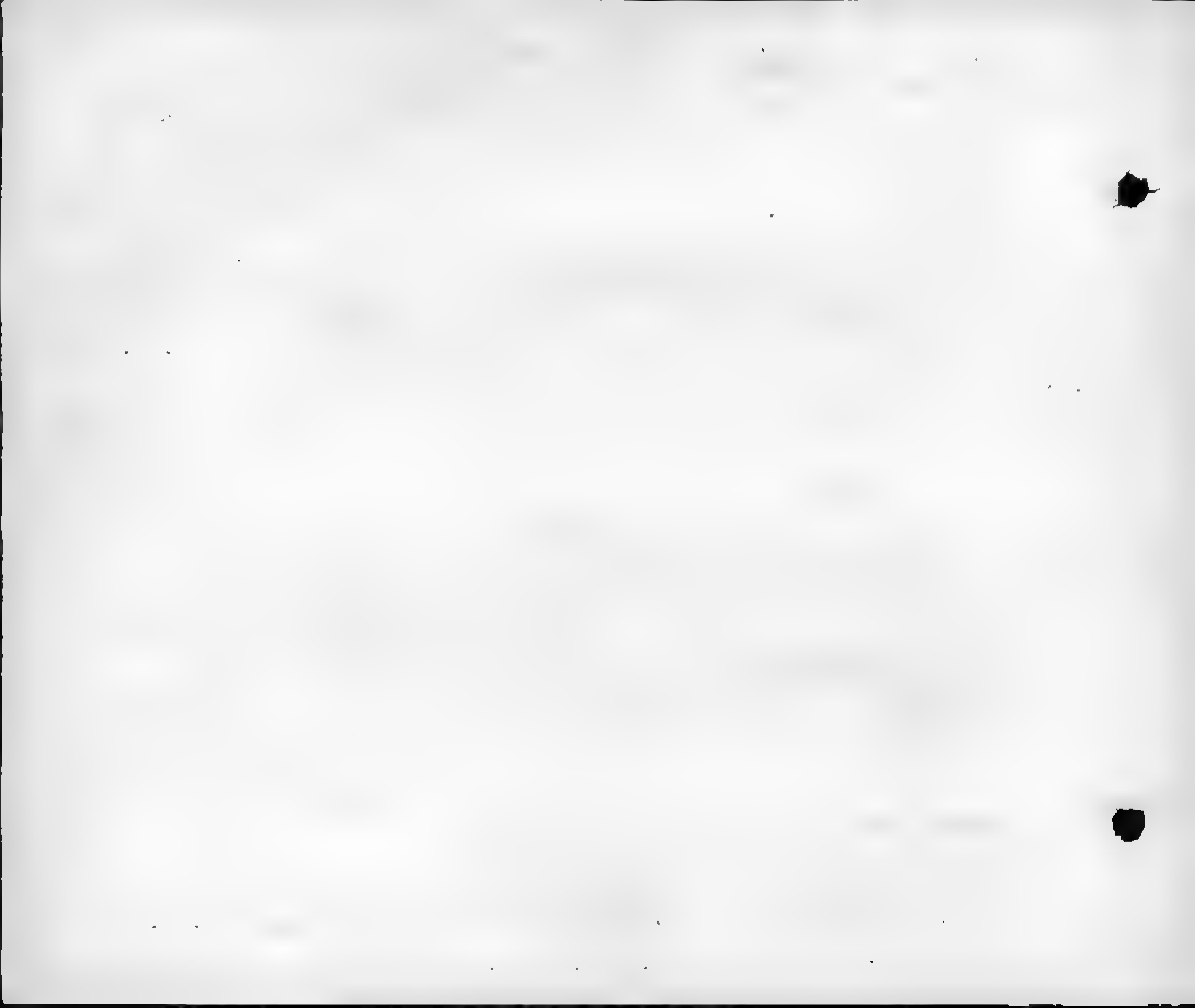
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## CERTIFICATE OF DEATH

10351

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>MONTGOMERY PG.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tokoma Park</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince George Hyattsville</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sant.</b>		d STREET ADDRESS <b>1100 Chillum Minor Dr</b>	
3 NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>M</b> Last <b>LAPONE</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 20 1887</b>
9 AGE (In years last birthday) <b>72</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11 BIRTHPLACE (State or foreign country) <b>Italy</b>	
13. FATHER'S NAME <b>James Morfesi</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Angeline Jackerson</b>		Address <b>1100 Chillum Minor Dr</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hypertensive Hem. Dis.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 12, 1959</b> , to <b>Sept 20, 1959</b> , that I last saw the deceased alive on <b>Sept 20, 1959</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Edw. J. Sullivan</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>9-5-1959 Dr. N.W. Weber DC</b>	
PHYSICIAN'S NAME (Type) <b>EDWARD J. SULLIVAN</b>			
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/28/59</b>	
22c NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>		ADDRESS <b>4812 Ga. Ave. Wash.</b>	
24a REC'D BY REGISTRAR <b>SEP 25 '59</b>		24b REGISTRAR'S SIGNATURE <b>Colton E. K...</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397

## CERTIFICATE OF DEATH

Reg. Dist. No.

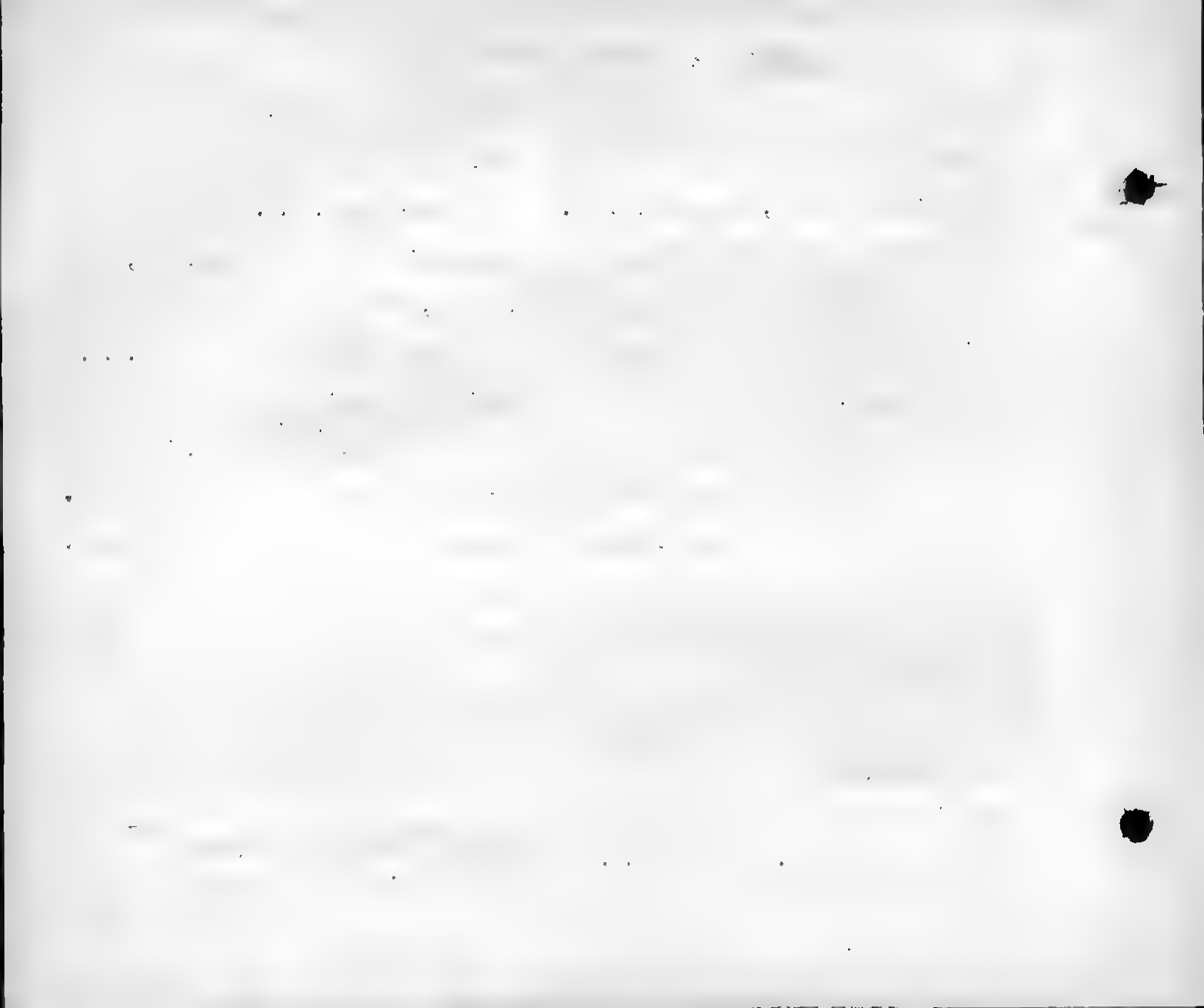
10352

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>80 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>5117 Benning Road, S.E.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Kathryn Mary Cappelli</b>				9. DATE OF DEATH Month Day Year <b>September 26, 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 2, 1956</b>		9. AGE (In years last birthday) yrs. <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Cappelli</b>				14. MOTHER'S MAIDEN NAME <b>Pauline Hnylanski</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute gastrointestinal hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphocytic leukemia</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>11 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>Bronchopneumonia, left upper lobe</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 8, 1959</b> , to <b>September 26, 1959</b> , that I last saw the deceased alive on <b>September 26, 1959</b> , and that death occurred at <b>1:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center Bethesda 14, Maryland</b> DATE SIGNED <b>9-26-59</b>							
ACTUAL SIGNATURE <b>Richard C. Mechanic, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Richard C. Mechanic, M.D.</b>		NATIONAL INSTITUTES OF HEALTH <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>				ADDRESS <b>517 11th St. S.E. Wash., D.C.</b>		24a. REC'D BY REGISTRAR <b>DET 1 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





10398

## CERTIFICATE OF DEATH

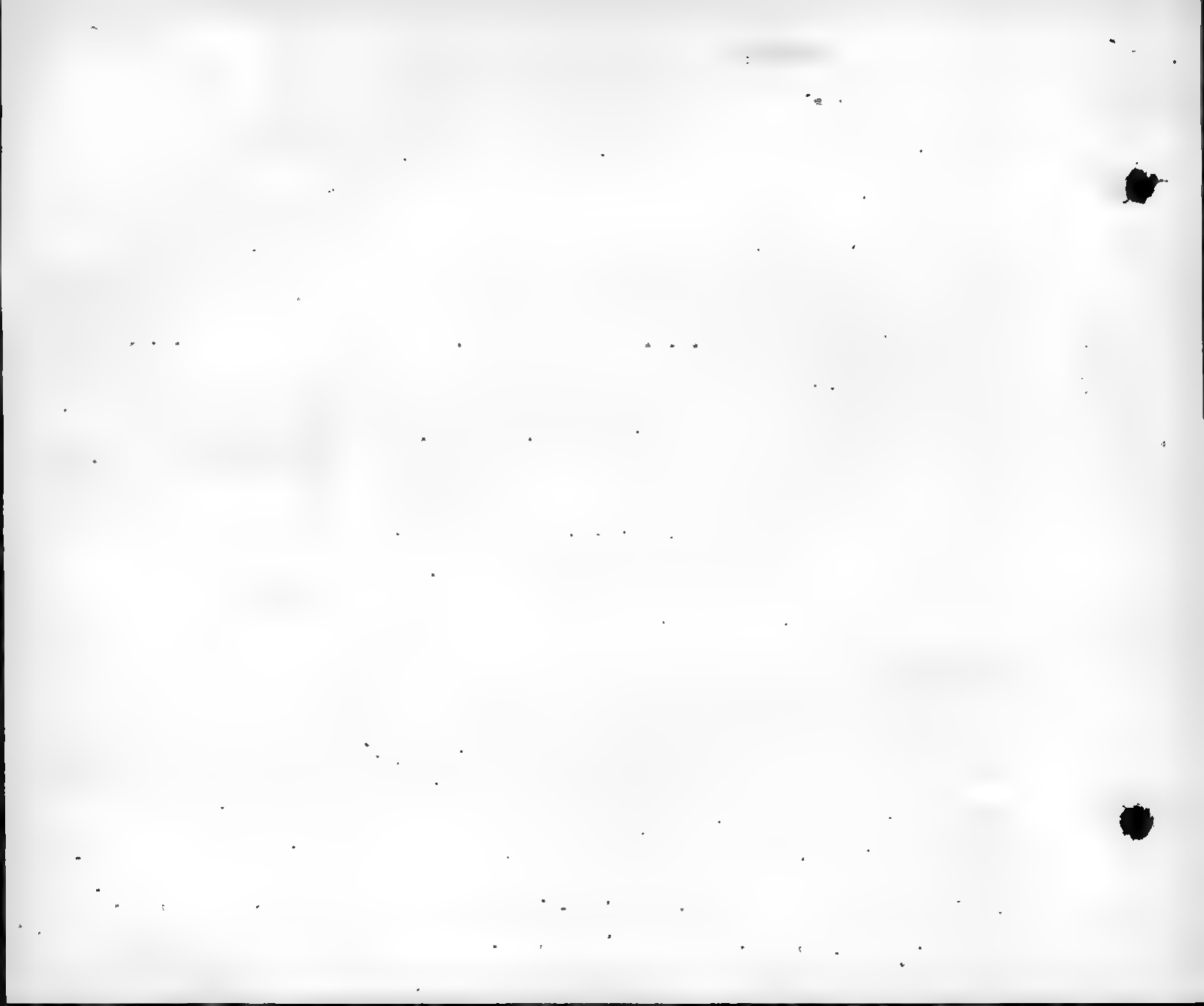
10353

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>14 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>621 RAY DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>M</b> Last <b>CARPENTER</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/27/75</b>
9. AGE (In years last birthday) <b>84</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G.A.O.</b>	11. BIRTHPLACE (State or foreign country) <b>MASS.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>CHARLES CARPENTER</b>		14. MOTHER'S MAIDEN NAME <b>MARIAM MARGAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Maude R. Carpenter, 621 Ray Drive</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Memia</b>			
DUE TO (b) <b>Coronary Vascular Renal Disease</b>			
DUE TO (c) <b>Brain arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Quadrilateral ulcer, Secondary tumor</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 17, 1958</b> to <b>Sept 19, 1959</b> that I last saw the deceased alive on <b>Sept 16, 1959</b> and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>J. J. Courtney</b> M.D.		ADDRESS (Street, city or town, state) <b>5601 - 4 St NW Washington DC</b>	
PHYSICIAN'S NAME (Type) <b>FX. COURTNEY M.D.</b>		DATE SIGNED <b>Sept 20/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/22/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur A. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10399

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 16 1 DAY				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MONTGOMERY b. COUNTY MARYLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE				d. STREET ADDRESS Box 381				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Baby Boy Carter				4. DATE OF DEATH Month Day Year SEPTEMBER 20 19 59				5. SEX MALE				6. COLOR OR RACE WHITE				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9/19/59				9. AGE (In years lost birthday) yrs. 27				10. IF UNDER 1 YEAR: Months Days Hours Min 40			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME CLARENCE NOLEN CARTER				14. MOTHER'S MAIDEN NAME HELEN CHRISTINE ROGERS											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO None				17. INFORMANT HOSPITAL RECORDS				Address OLNEY, MARYLAND				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from 9/19 1959, to 9/20 1959, that I last saw the deceased alive on 9/20 1959, and that death occurred at 8:40 P.M. from the causes and on the date stated above																ADDRESS (Street, city or town, state)				DATE SIGNED 9/20/59											
ACTUAL SIGNATURE <u>B. Meadors</u>				M.D.				PHYSICIAN'S NAME (Type) G. F. MEADORS, M. D.				DAMASCUS, MARYLAND																			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF Sept 22, 1959				22c. NAME OF CEMETERY OR CREMATORY DARNESTOWN Fresh Cem				22d. LOCATION (City, town, or county) (State) DARNESTOWN, MD																			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				ADDRESS Bethesda, Md				24a. REC'D BY REGISTRAR DATE SEP 24 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kram																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



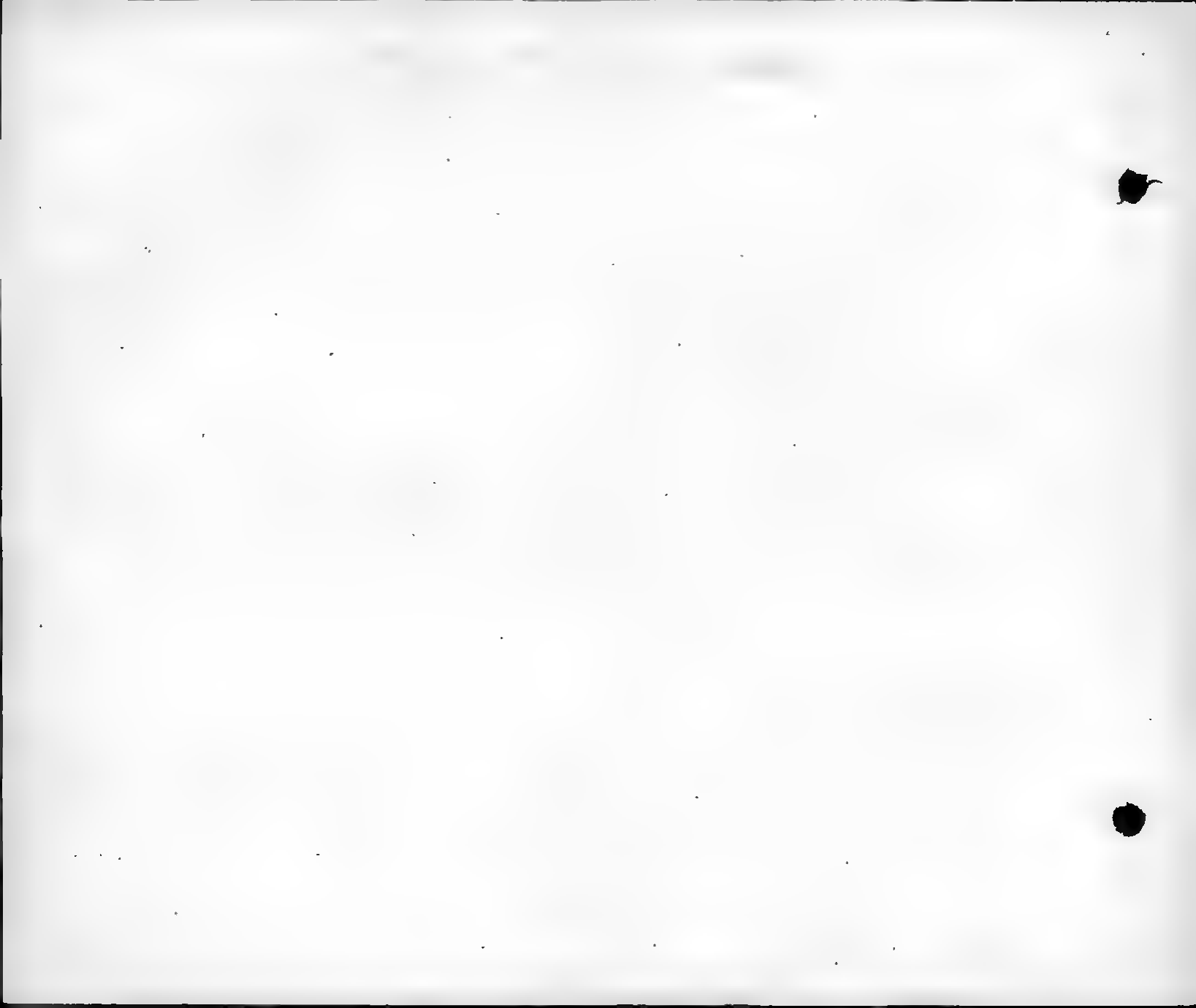
10400

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>17 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8210 16TH STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA ESTELLE CASHELL</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 3 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 20, 1871</u>
9. AGE (In years last birthday) <u>87 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE M. CECIL</u>		14. MOTHER'S MAIDEN NAME <u>SARAH J. ROLKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>MARY LEE CASHELL</u>		Address <u>AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ATHEROSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>3 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 9</u> , 1957, to <u>SEPT. 3</u> , 1959, that I last saw the deceased alive on <u>SEPT. 3</u> , 1959, and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>James A. Roberts</u> M.D. <u>8907 GEORGIA AVE N.W.</u> <u>SEPT. 3, 1959</u>			
ACTUAL SIGNATURE <u>James A. Roberts</u>		M.D. <u>8907 GEORGIA AVE N.W.</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		<u>SILVER SPRING, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCKVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may remain in the hospital or attending physician's possession. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10356**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>few hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8009 Kentucky Dr</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Montg</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cherry Chase</b> d. STREET ADDRESS <b>3704 Manor Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Laban Christopher Chappell</b> First Middle Last <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>11-15-1901</b> <b>9. AGE</b> (In years last birthday) <b>57 yrs.</b> <b>10. IF UNDER 1 YEAR</b> Months <b>14</b> Days <b>19</b> <b>11. IF UNDER 24 HRS.</b> Hours <b>57</b> Min.		<b>4. DATE OF DEATH</b> <b>Sept 14 1959</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Govt</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Fed Housing</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>S.C.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Laban C. Chappell</b> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Marta Ann Montiphi</b> <b>17. INFORMANT</b> <b>Isabel Chappell - Sister I</b> <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO <b>hanging</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>hanging</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Hung self by neck in sister's home</b> <b>20c. TIME OF INJURY</b> Month, Day, Year <b>9-14 1959</b> Hour <b>9-14</b> a.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b> <b>20f. (City or town)</b> <b>Bethesda</b> (County) <b>Montg</b> (State) <b>md</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>			
<b>ACTUAL SIGNATURE</b> <b>Frank J. Boeschert</b> <b>M.D.</b> <b>NAME (Type)</b> <b>FRANK J. BOESCHERT</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>9-14-59</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>9/17/59</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Parklawn Cemetery</b> <b>22d. LOCATION (City, town, or county)</b> <b>Rockville, Maryland</b>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b> <b>ADDRESS</b> <b>Bethesda, Maryland</b> <b>24a. REC'D BY REGISTRAR</b> <b>SEP 17 '59</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur E. Hines</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





10402

## CERTIFICATE OF DEATH

Reg. Dist. No.

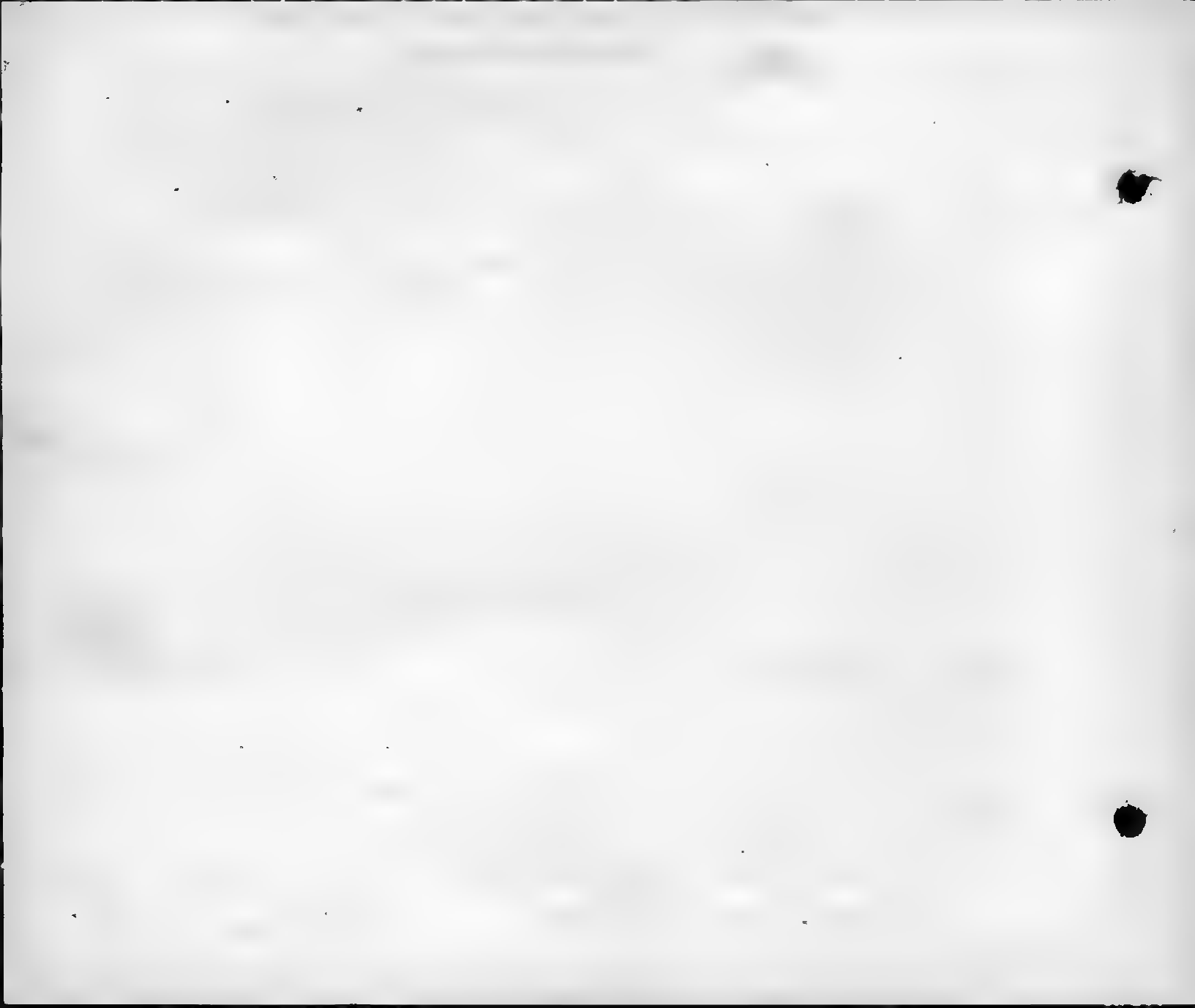
10357

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Chester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paoli</u>	
c. LENGTH OF STAY IN 1b <u>1 yr.</u>		d. STREET ADDRESS <u>5454 Jolina Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank Martin Church</u>		4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director of Music</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Phillip Church</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Hamilton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Mrs. Robt. Walker</u>		Address <u>7103 Fla. St. Ch. Ch. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 hr</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7 July 1959 to 28 Sept 1959</u> that I last saw the deceased alive on <u>Sept 28 1959</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Roy B. Parsons Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Bartonville, Md.</u> DATE SIGNED <u>9-28-59</u>	
PHYSICIAN'S NAME (Type) <u>Roy B. Parsons Jr. MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>Sept. 28 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belvidere</u>	22d. LOCATION (City, town, or county) (State) <u>Belvidere Penn.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u>		24a. REC'D BY REGISTRAR <u>Arthur A. Hines</u> DATE <u>OCT 2 '59</u>	
Address <u>Saylorsville Md.</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



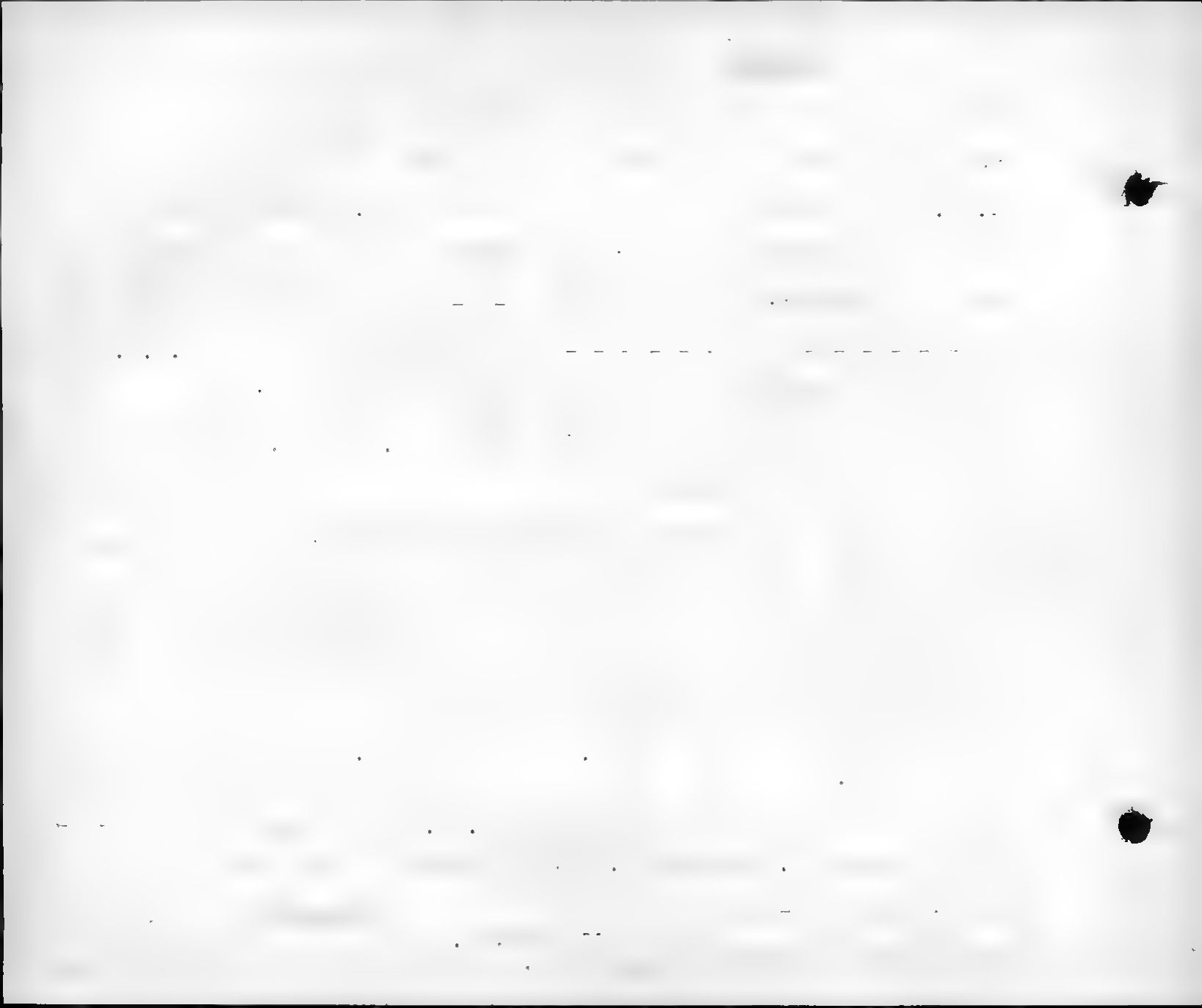
10403

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>14 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>			2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admiss on) a. STATE <b>Virginia</b> b. COUNTY <b>Triangle</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>826 3</b> d. STREET ADDRESS <b>31 Mason Dr., Thomason Park</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Middle Last <b>Daniel Guy CILLEY</b>			4. DATE OF DEATH Month Day Year <b>September 15 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-59</b>	9. AGE (In years last birthday) <b>1</b> yrs	IF UNDER 1 YEAR Months <b>1</b> Days <b>22</b> Hours <b></b> Min <b></b>
10a. JSLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>- - - - -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Herbert Leo CILLEY</b>			14. MOTHER'S MAIDEN NAME <b>Marie Elizabeth SIMARD</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO <b>None</b>		
17. INFORMANT <b>(F) Herbert L. Cilley, same as #2</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>757.1</b> DUE TO Conditions, if any which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Bilateral polycystic kidney disease</b> DUE TO (c) <b>From birth</b>					INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Falmouth Maine</b>	
20f. (City or town) <b>Falmouth</b>		(County) <b>Maine</b>		(State) <b>Maine</b>	
21. I certify that I attended the deceased from <b>Sept. 1 1959</b> to <b>Sept. 15 1959</b> that I last saw the deceased alive on <b>Sept. 15 1959</b> , and that death occurred at <b>1240AM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Robert T. Brooks Jr.</b> PHYSICIAN'S NAME (Type) <b>Robert T. BROOKS, Jr., LT, MC, Bethesda, Maryland</b>				ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>9-15-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 9-16-59</b>		22b. DATE THEREOF <b>9-16-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington, Va.</b>	
22d. LOCATION (City, town, or county) <b>Falmouth</b>		(State) <b>Maine</b>		24a. REC'D BY REGISTRAR <b>SEP 18 '59</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ives Funeral Home, 2847 Wilson Blvd.</b>		ADDRESS <b>Arlington, Va.</b>		24b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

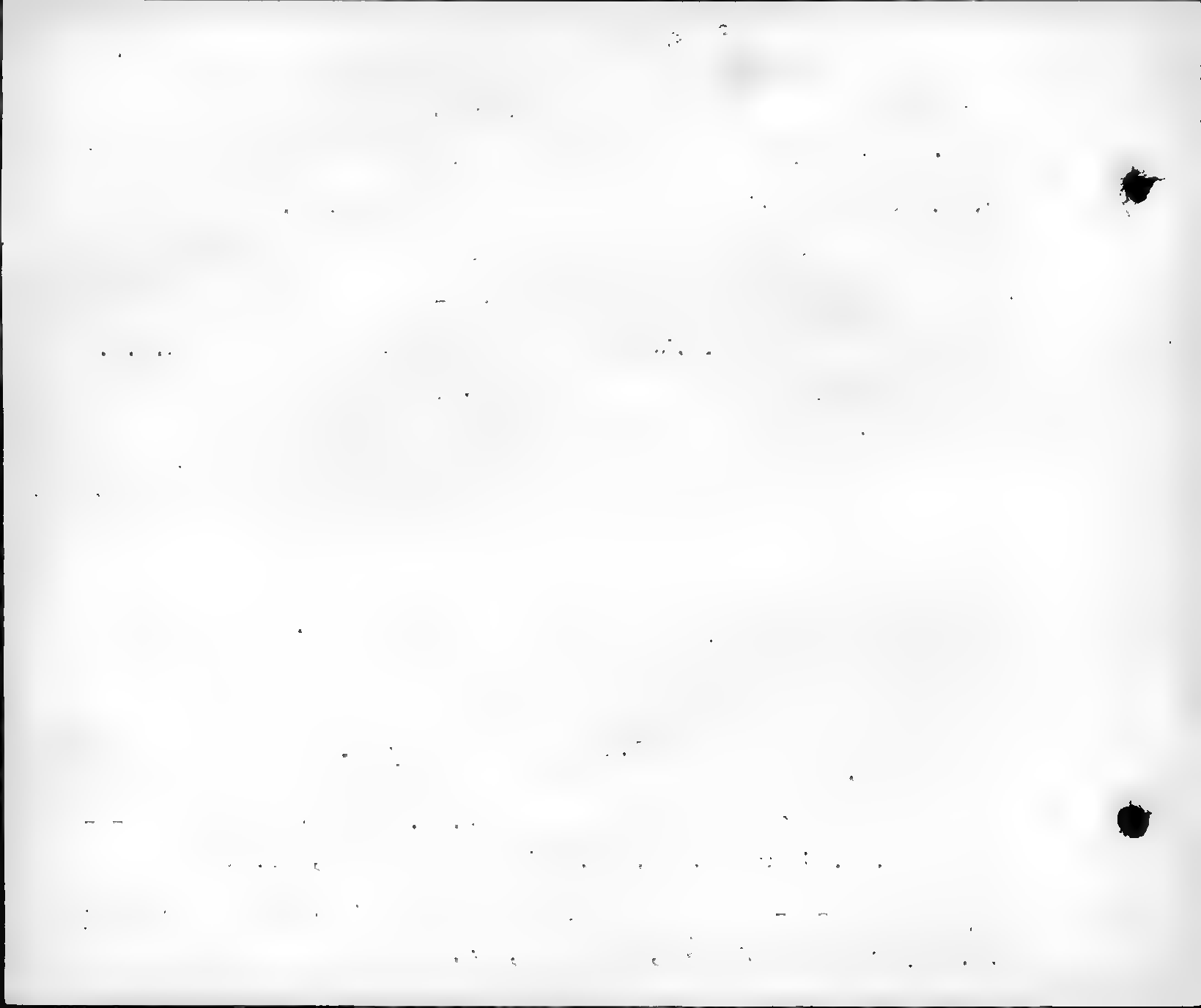
Reg. Dist. No. 215

10404

1. PLACE OF DEATH COUNTY <b>Montgomery</b> STATE <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) STATE <b>Virginia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>	c. LENGTH OF STAY IN lb <b>41 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Richmond</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>4500 Dunston Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Emory</b> Middle <b>Fitch</b> Last <b>CLEMENT</b>		4. DATE OF DEATH Month <b>September</b> Day <b>9</b> Year <b>1959</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-17-87</b>
9 AGE (In years last birthday) yrs <b>71</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Maynard CLEMENT</b>	
14. MOTHER'S MAIDEN NAME <b>Clara FITCH</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> <b>WWI &amp; II</b>	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA E METASTASES</b> INTERVAL BETWEEN ONSET AND DEATH <b>MULTIPLE COMONTHS</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE E SEVERE CONGESTIVE FAILURE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 30</b> , 19 <b>59</b> , to <b>Sept. 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 8</b> , 19 <b>59</b> , and that death occurred at <b>7:00AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>9-9-59</b>			
ACTUAL SIGNATURE <b>F. S. Caldwell</b> M.D.		U. S. Naval Hospital <b>9-9-59</b>	
PHYSICIAN'S NAME (Type) <b>F. S. CALDWELL, LT, MC, USN Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>cremation</b>	22b. DATE THEREOF <b>9-10-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hills Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Humphrey</b>		24a. REC'D BY REGISTRAR <b>SEP 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur J. K...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

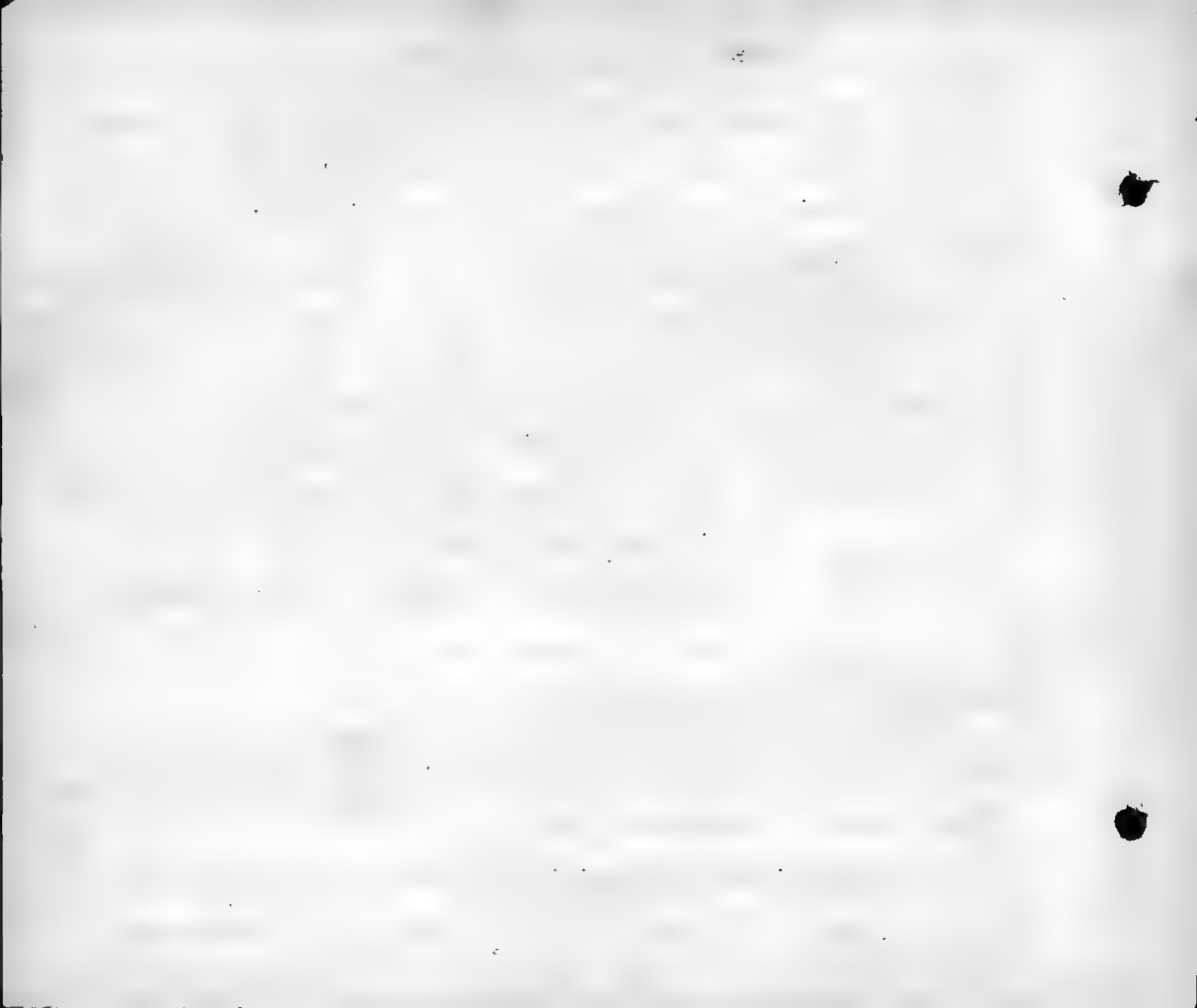
10360

10405

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LeDeau Gardens Nursing Home</u>		d. STREET ADDRESS <u>12225 Selfridge Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>Dora</u> Last <u>Clore</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasia</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 20, 1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Madison Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACKSON GOAR</u>		14. MOTHER'S MAIDEN NAME <u>Sarah May</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>579-24-529</u>	
17. INFORMANT <u>Mrs Harold Hyre</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Carcinoma, Lung, Right</u> DUE TO (c) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>  <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Sep 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sep 15</u> , 19 <u>59</u> , and that death occurred at <u>7:10 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert T. Thibadeau</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>10609 Concord Street</u> <u>Sep 16, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau, M.D.</u>		<u>Kensington, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>PR. Geo. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO., 1400 Chapin St., N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur G. Kane</u>			





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X  
X  
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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician, but after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

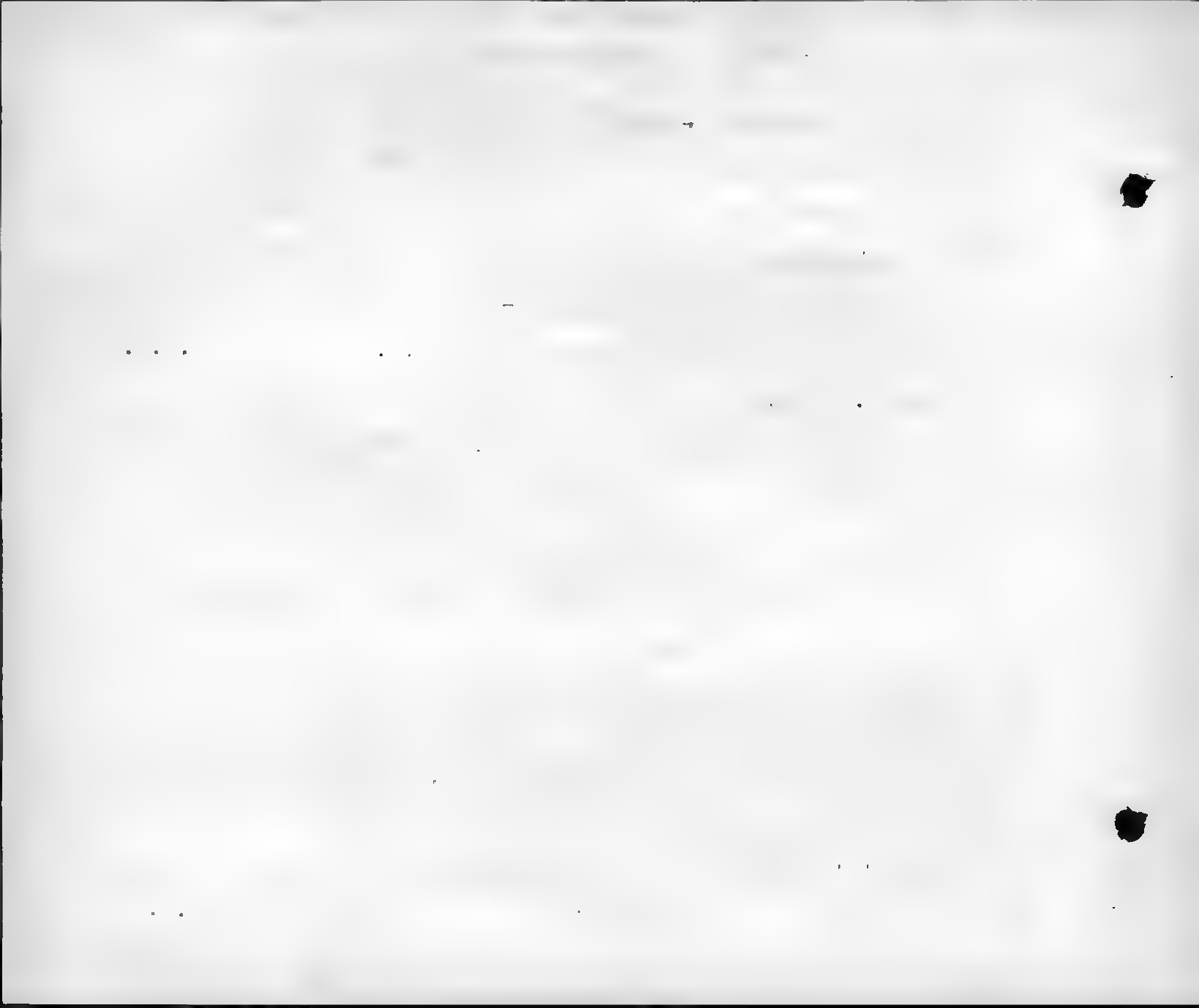
10405

CERTIFICATE OF DEATH

Reg. Dist. No.

10361

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
c. LENGTH OF STAY IN 1b <b>3 yrs 6 mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3000 McComas Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Solon Cooper</b>		4. DATE OF DEATH <b>Sept 14th 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-9-1871</b>
9. AGE (In years last birthday) <b>88</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel Business Wash, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George H. Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>June C. Reynolds</b>		<b>5326 Willard Ave Chevy Chase, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Carcinomatosis Arterio-</b> DUE TO <b>Sclerotic Disease</b> (c) <b>Carcinoma of the Colon</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 19 56</b> to <b>Sept 14th 19 59</b> that I last saw the deceased alive on <b>Sept 13th 19 59</b> , and that death occurred at <b>2:05 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8106 Maple Ridge Road Bethesda 14, Maryland</b> DATE SIGNED <b>9-14-59</b>			
ACTUAL SIGNATURE <b>W.T. Joyce</b>		M.D. <b>8106 Maple Ridge Road</b>	
PHYSICIAN'S NAME (Type) <b>W.T. Joyce</b>		DATE <b>SEP 16 59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-16-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Mattingly</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10407 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10362

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Montgomery</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">New York</span> b. COUNTY <span style="font-size: 1.2em;">Levittown</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Bethesda</span>		c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">3½ hrs.</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Levittown</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Suburban Hospital</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">19 Abbey Lane</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <span style="font-size: 1.2em;">Lucy</span></span> <span>Middle <span style="font-size: 1.2em;">Creamer</span></span> <span>Last</span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <span style="font-size: 1.2em;">Sept 20,</span></span> <span>Day <span style="font-size: 1.2em;">19</span></span> <span>Year <span style="font-size: 1.2em;">1959</span></span> </div>			
5. SEX <span style="font-size: 1.2em;">female</span>		6. COLOR OR RACE <span style="font-size: 1.2em;">white</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">April ? 1921</span>	
9. AGE (In years last birthday) <span style="font-size: 1.2em;">38 yrs.</span>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">housewife</span>		10b. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">—</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Va.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">John Sudduth</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Lena Jones</span>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <span style="font-size: 1.2em;">—</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">—</span>		17. INFORMANT Address <span style="font-size: 1.2em;">Alice P. Bean, 7019 Ga. Ave., Silver Spring Md.</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex;"> <div style="flex: 1;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Exsanguination</span>            DUE TO <span style="font-size: 1.2em;">825X</span>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         </div> <div style="flex: 1;">           (b) <span style="font-size: 1.2em;">Ruptured Spleen</span>            DUE TO <span style="font-size: 1.2em;">Automobile accident</span> </div> <div style="flex: 1;">           (c) <span style="font-size: 1.2em;">—</span> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <span style="font-size: 1.2em;">Multiple fractures, head injuries, internal injuries</span>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3½ hours</span>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <span style="font-size: 1.2em;">Auto accident</span>			
20c. TIME OF INJURY Month, Day, Year <span style="font-size: 1.2em;">12:20 o. m. 9/20/59</span>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">highway</span>		20f. (City or town) (County) (State) <span style="font-size: 1.2em;">Bethesda Montg. Md.</span>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <span style="font-size: 1.2em;">Frank J. Broschart</span> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <span style="font-size: 1.2em;">Frank J. Broschart</span>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <span style="font-size: 1.2em;">9/20/59</span>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		22b. DATE THEREOF <span style="font-size: 1.2em;">9-24-1959</span>		22c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Long Island National Cemetery Farmingdale, Long Island, N. Y.</span>		22d. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">—</span>	
23. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.2em;">H. Don. H. Vol 2224-Wis. Am. D.C.</span>				ADDRESS <span style="font-size: 1.2em;">—</span>		24a. REC'D BY REGISTRAR DATE <span style="font-size: 1.2em;">SEP 22 '59</span>	
24b. REG. STRAR'S SIGNATURE <span style="font-size: 1.2em;">Arthur L. Frank</span>				24c. REG. STRAR'S SIGNATURE <span style="font-size: 1.2em;">—</span>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

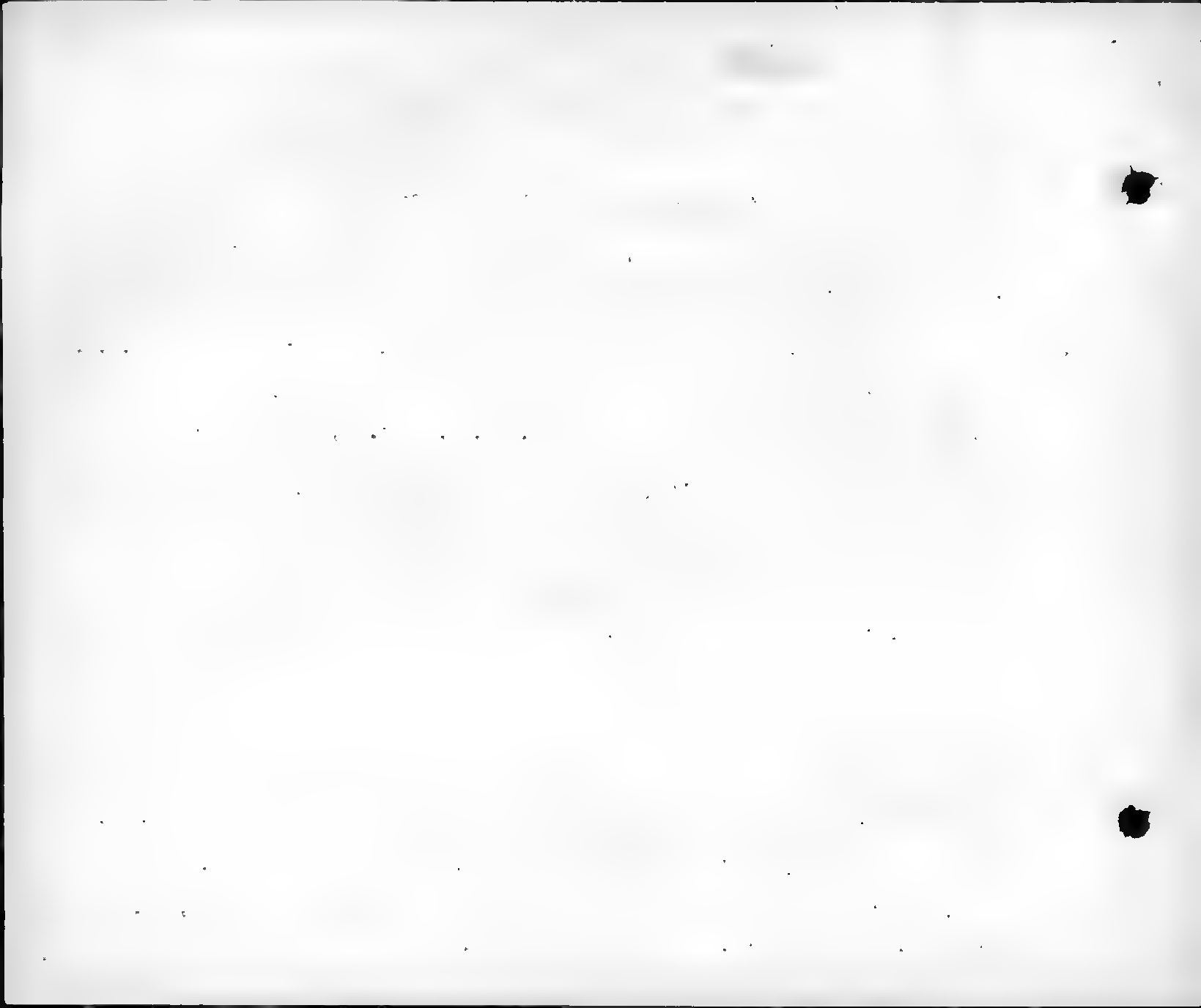
10363

10408

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLONIAL HEIGHTS 83X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>		d. STREET ADDRESS <b>148 Roanoke Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>T.</b> Last <b>CREIGHTON</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/81</b>
9. AGE (In years last birthday) <b>78</b> yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Liverpool, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JONATHAN CREIGHTON</b>		14. MOTHER'S MAIDEN NAME <b>Sarah unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>INFORMANT Mrs. W. L. Douglas, Olney, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive GI Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ASHD - hypertension</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-5</b> , 19 <b>59</b> , to <b>9-18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-18</b> , 19 <b>59</b> , and that death occurred at <b>2:10 PM</b> , from the causes and on the date stated above. (ADDRESS (Street, city or town, state) DATE SIGNED <b>4404 Greenbush Rd. Riverdale Md</b>			
ACTUAL SIGNATURE <b>Roy B Parsons Jr</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Roy B Parsons Jr</b>			
22a. BURIAL CREMATION ON REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>	22b. DATE THEREOF <b>9/18/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Colonial Heights, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC. Silver Spring, Md.</b> <b>Claymond A. Ziska</b>		24a. REC'D BY REGISTRAR <b>SEP 21 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. L. &amp; F. H. H.</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

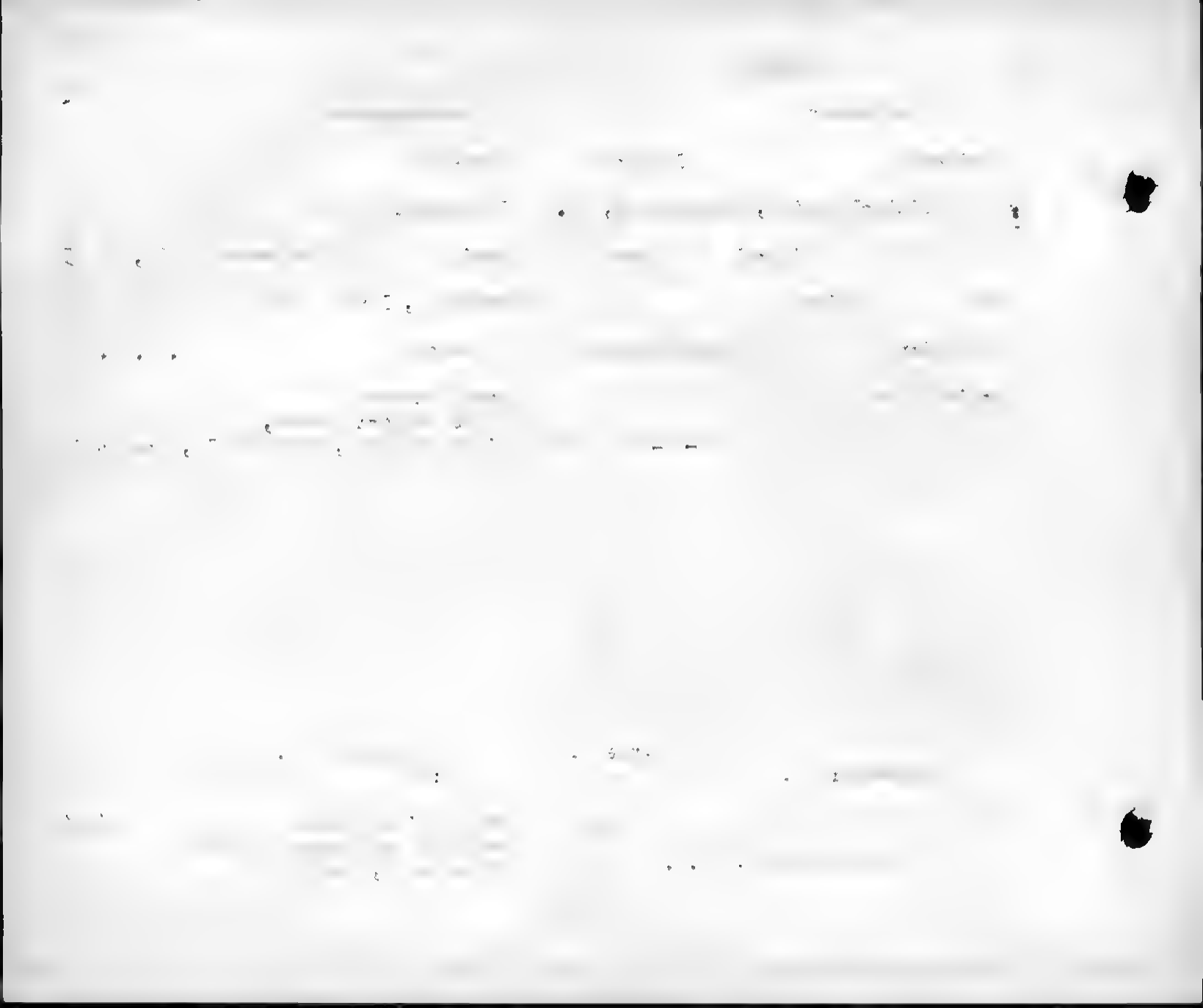
Reg. Dist. No.

10364

10409

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE <b>Massachusetts</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>116 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>10 Stoddard Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>(none)</b> Last <b>Gronin</b>				4. DATE OF DEATH Month <b>September</b> Day <b>30,</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 9, 1899</b>	
9. AGE (In years last birthday) <b>59</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>City Ordinance</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
13. FATHER'S NAME <b>Daniel Gronin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Donahue</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>034-09-7771</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>034-09-7771</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary and Cardiac Insufficiency</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma to lungs + heart</b> DUE TO (c) <b>Carcinoma of the Pancreas</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>3 months</b> <b>2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from <b>June 6,</b> 19 <b>59</b> , to <b>September 30,</b> 19 <b>59</b> , that I last saw the deceased alive on <b>September 30,</b> 19 <b>59</b> , and that death occurred at <b>7:01A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center</b> <b>9/30/59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE: <b>Leon Rosenberg</b>				PHYSICIAN'S NAME (Type) <b>Leon Rosenberg, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>SHIP RR.</b>		<b>9-30-1959</b>		<b>ST JOHN'S CEMETERY</b>		<b>WORCESTER MASS</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>				ADDRESS <b>1400 Chapin St NW</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 5 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur B. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





10410

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN lb <b>82 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Clara Mae CRITCHFIELD</b>				4. DATE OF DEATH <b>September 24 1959</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8-1-86</b>	9 AGE (in years lost birthday) <b>73</b> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11 BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>George PRINCE</b>				14. MOTHER'S MAIDEN NAME <b>Maryette SPURGEON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16 SOCIAL SECURITY NO <b>577 01 6081</b>			
17. INFORMANT <b>(Daughter) Ruth C. REID</b>				Address <b>Same as #2</b>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Lymphosarcoma</b> <b>200.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4 July 1959</b> to <b>24 Sept 1959</b> that I last saw the deceased alive on <b>24 September 1959</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>R. G. Muth</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>R. G. MUTH LT MC USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-30-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ripley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Big Prairie Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert G. Bates</b>				24a. REC'D BY REGISTRAR <b>AMH</b>		24b. REGISTRAR'S SIGNATURE	
Chamber Funeral Home 3072 "M" Street Washington D.C.							

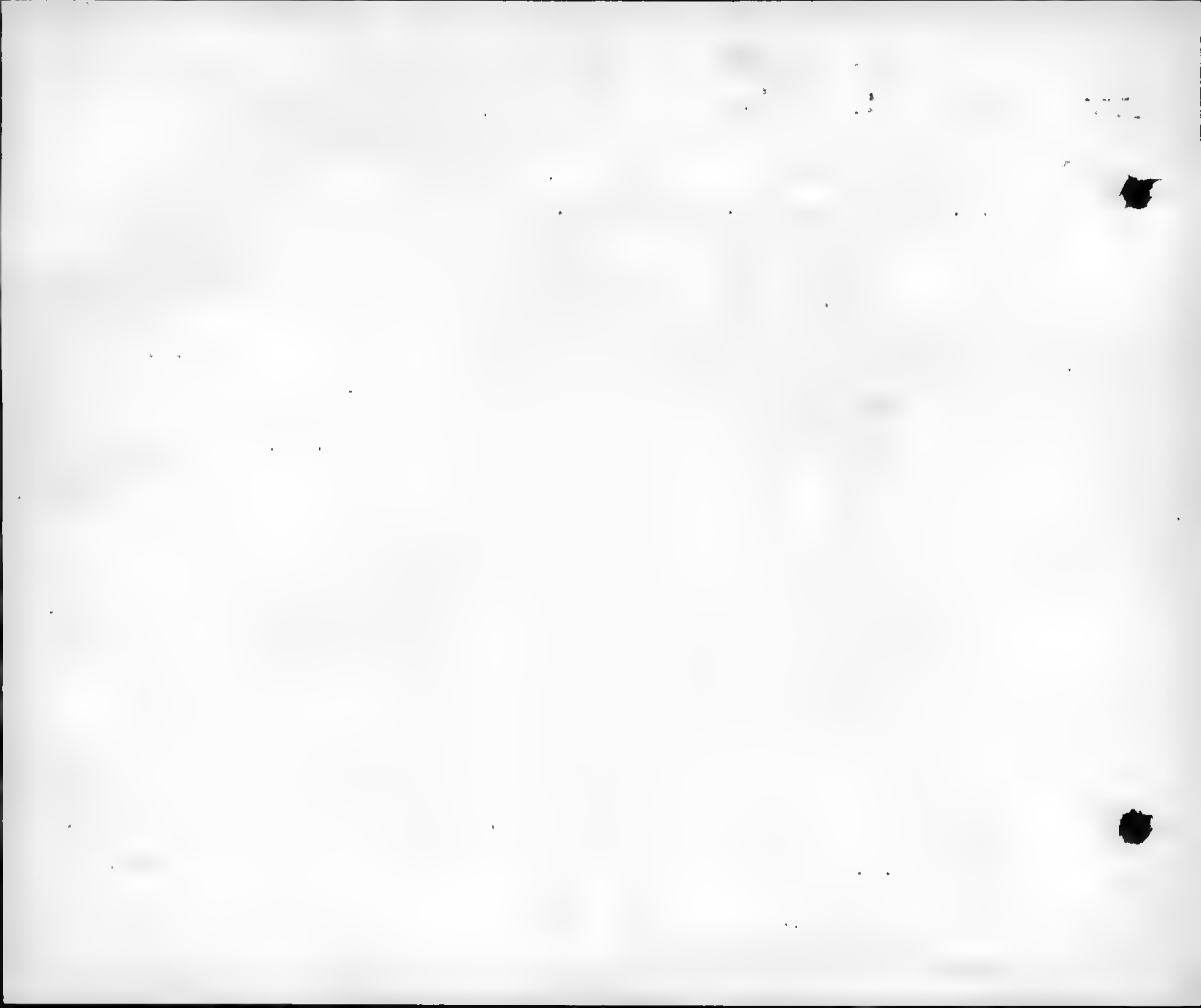
VS A15 (4)  
ISM 9/58

SEP 30 '59

Arthur J. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10366

10411

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>3 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC. Box 69</b>				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> d. STREET ADDRESS <b>Box 69</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GLADYS JENNETTE CROSBY</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>20</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/7/09</b>	
9. AGE (In years last birthday) yrs. <b>50</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES GARFIEDL DEGARMO</b>				14. MOTHER'S MAIDEN NAME <b>LILLIAN VIOLA SPEED</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>046-20-2515</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> Address <b>OLNEY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ben. Ca. = Metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Inflammatory Ca. Rt. Breast</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6. mo.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>OLNEY</b>				20g. (County) <b>MONTGOMERY</b>		20h. (State) <b>MARYLAND</b>	
21. I certify that I attended the deceased from <b>22 March, 1959</b> , to <b>20 Sept, 1959</b> , that I last saw the deceased alive on <b>19 Sept, 1959</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Box 69, Olney, Md.</b> DATE SIGNED <b>21 Sept 59</b>							
ACTUAL SIGNATURE <b>John Bozhy Ziegler M.D.</b>				PHYSICIAN'S NAME (Type) <b>J. B. ZIEGLER M.D.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	
22d. LOCATION (City, town, or county) <b>Silver Spring, Maryland</b>				22e. (State) <b>MARYLAND</b>		22f. (Country) <b>USA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler-1331 E. Montg. Ave/ Rockville, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10412

## CERTIFICATE OF DEATH

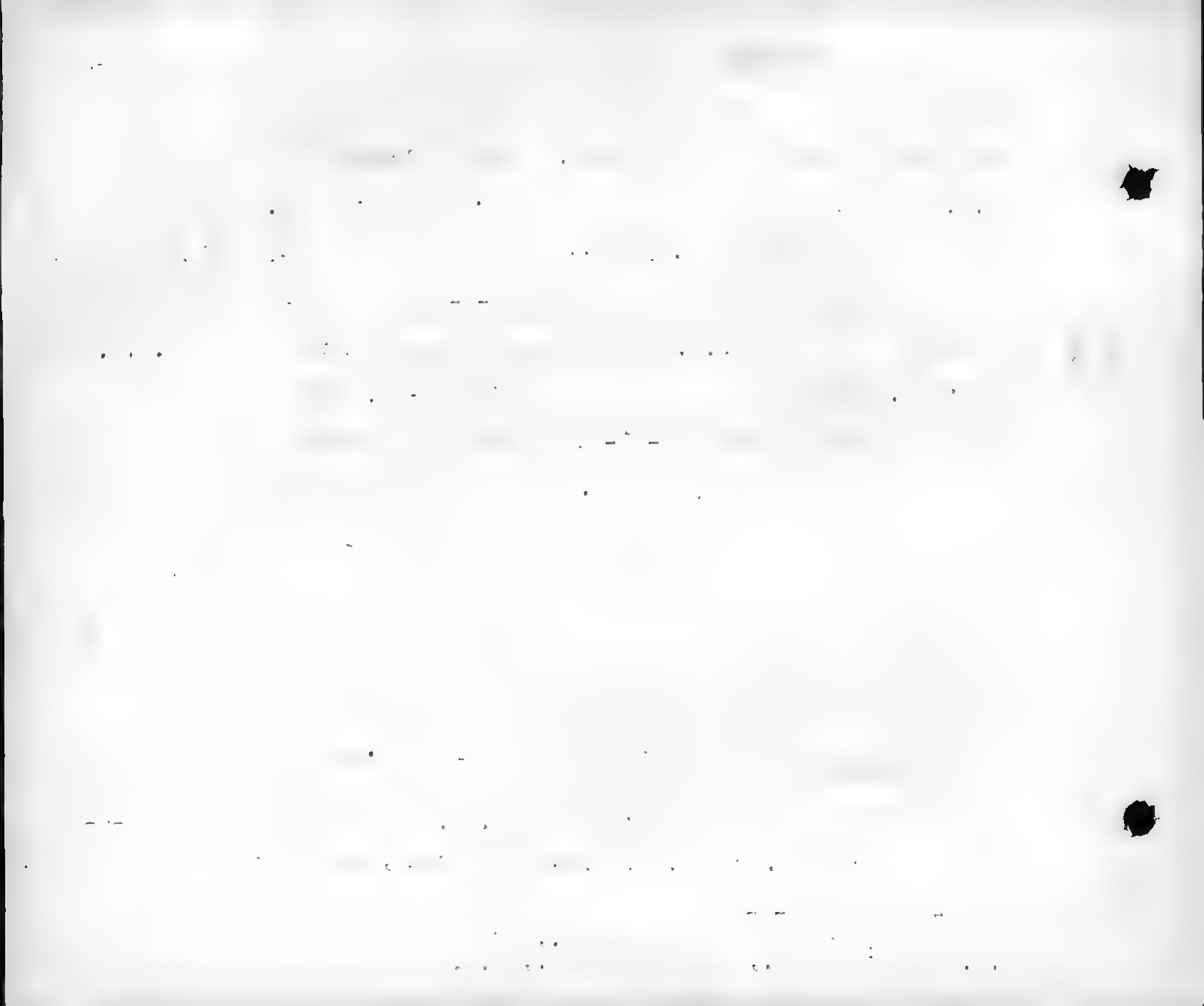
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>97 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institut on Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Turtle Creek</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Turtle Creek</b> d. STREET ADDRESS <b>350 McMasters Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Donald Carl Dunn CURRIE</b>		4. DATE OF DEATH Month Day Year <b>September 7 1959</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Caucasian</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-5-40</b>
9. AGE (In years last birthday) yrs <b>19</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marine</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corps</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James G. CURRIE</b>		14. MOTHER'S MAIDEN NAME <b>Dolores J. DUNN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO (If yes, give year or dates of service) <b>9/1948 to DD</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Widely disseminated sarcoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sarcoma Reticulum Cell type</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 2</b> , 19 <b>59</b> , to <b>September 7, 1959</b> , that I last saw the deceased alive on <b>September 6</b> , 19 <b>59</b> , and that death occurred at <b>11:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>William P. Baker</b> M.D. <b>U. S. Naval Hospital</b> <b>9-8-59</b>			
ACTUAL SIGNATURE <b>William P. BAKER, LT, MC, USN Bethesda, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 9-9-59</b>		22b. DATE THEREOF <b>9-9-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>--</b>		22d. LOCATION (City town or county) (State) <b>Turtle Creek, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chmabers &amp; Co., 1400 Chapin St., N.W.</b>		24. REC'D BY REGISTRAR <b>DATE SEP 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cap and papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

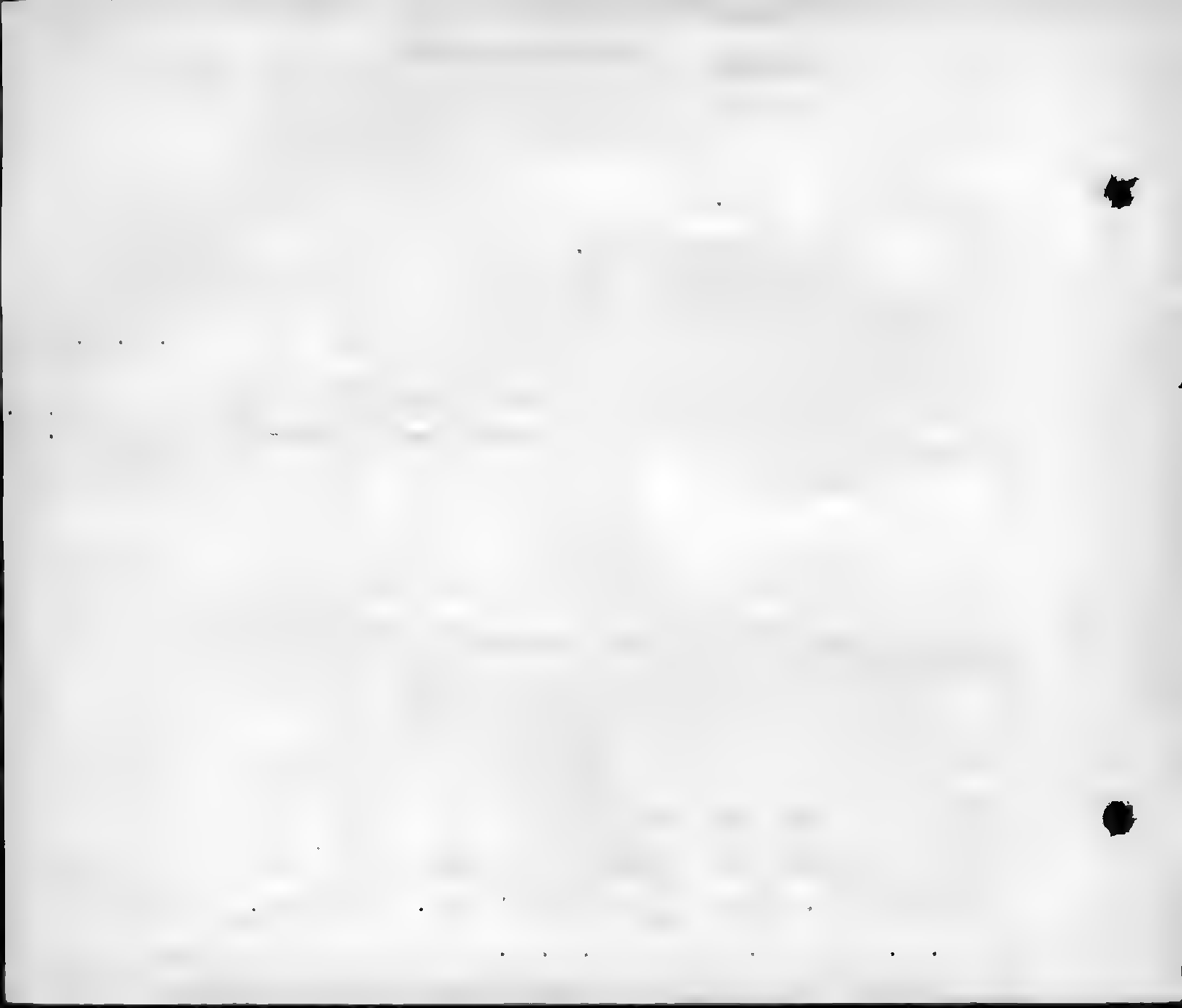
Reg. Dist. No.

10413

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. LENGTH OF STAY IN 1b <b>unobtainable</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>196 Primrose Street</b>				d. STREET ADDRESS <b>106 Primrose Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Wilhelmina</b> Middle <b>A.</b> Last <b>CURTISS</b>				4. DATE OF DEATH Month <b>9</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/5/1900</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Hoch</b>				14. MOTHER'S MAIDEN NAME <b>unobtainable</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO <b>no</b>		17. INFORMANT <b>Charles Lewis Curtiss</b>	
Address <b>Chevy Chase, Md.</b>				106 Primrose St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary Heart disease</b> DUE TO (c) <b>Cardio Vascular disease</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS.</b> <b>4 HRS.</b> <b>8 HRS.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NO</b>							
19. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 10</b> 19 <b>54</b> , to <b>Sept 30</b> 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 28</b> 19 <b>59</b> , and that death occurred at <b>4:13 P.</b> M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>1922 Biltmore St. NW</b> DATE SIGNED <b>Sept 30 1959</b>							
ACTUAL SIGNATURE <b>E. F. Quaxle</b> M.D. <b>Washington D.C.</b>							
PHYSICIAN'S NAME (Type) <b>E. F. Quaxle</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 5, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington, D. C.</b>				24a. REC'D BY REGISTRAR <b>Oct 5 1959</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10349

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONT.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAYLOR PARK</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SAN. HOSPITAL</u>				d. STREET ADDRESS <u>4614 ASPEN HILL CT.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>GERALD</u> Last <u>DEGROUCHY</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1959</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 7 1959</u>	9. AGE (In years last birthday) yrs <u>19</u>	IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER DE GROUCHY</u>				14. MOTHER'S MAIDEN NAME <u>ISABEL DEAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>HOSPITAL RECORDS W.S.H.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital hypoplasia of kidneys, list</u> <u>757.2</u> DUE TO <u>complicated by electrolyte imbalance</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>+ acidosis</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/22</u> , 19 <u>59</u> , to <u>9/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/26</u> , 19 <u>59</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James R. Coleman M.D.</u>				ADDRESS (Street, city or town, state) <u>733 Sleigh Avenue</u>		DATE SIGNED <u>9/26/59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>				<u>Silver Spring Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-28-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Spall's Funeral Home Mt. Rainier</u>				ADDRESS <u>2075 234 XUV</u>		24a. REC'D BY REGISTRAR <u>SEP 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10350

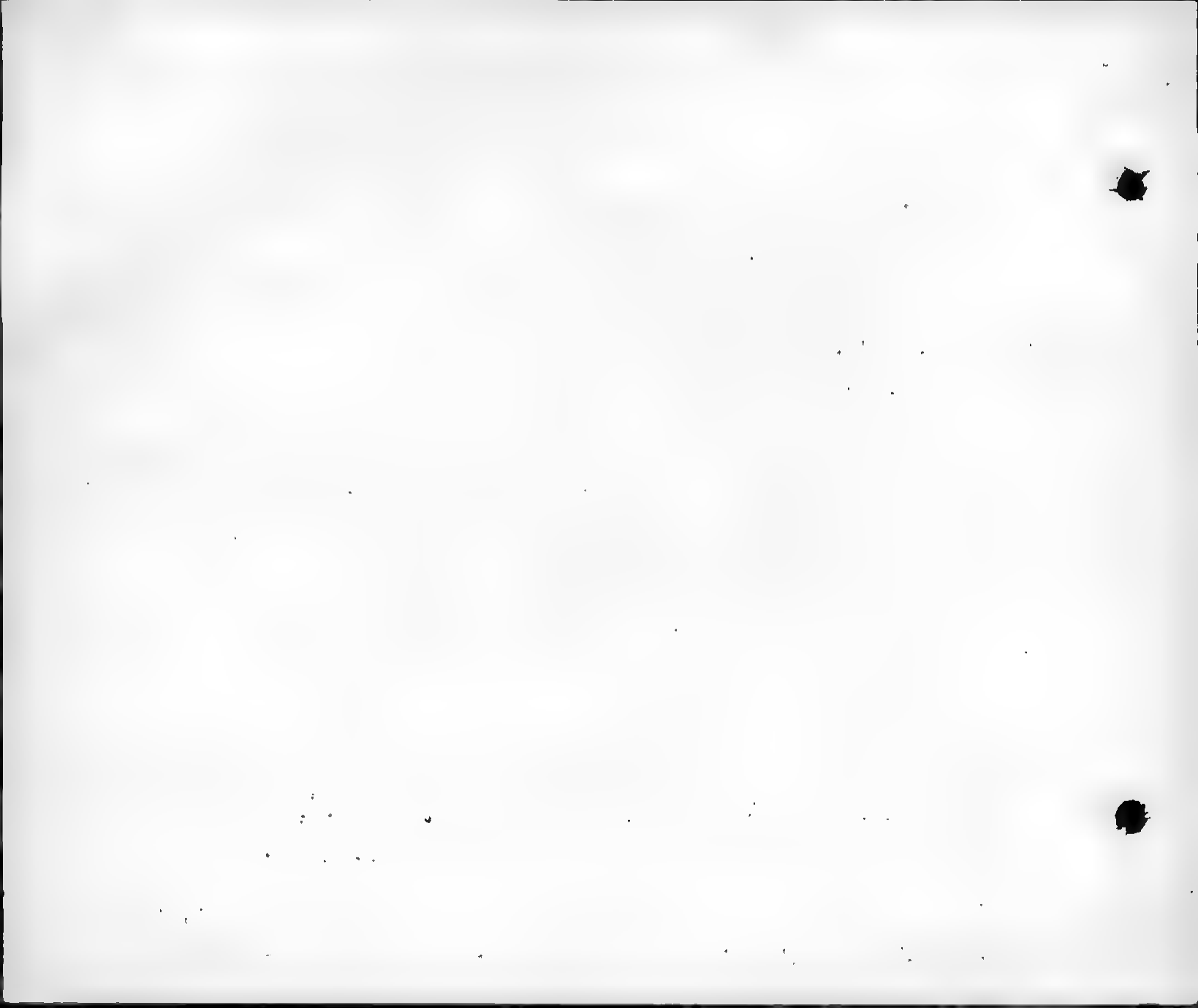
CERTIFICATE OF DEATH

Reg. Dist. No.

10370

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>81 days</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash Spr &amp; Hosp.</i>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> d. STREET ADDRESS <i>505 Domee Ave.</i> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Marie</i> Middle <i>Catherine</i> Last <i>Dinsmore</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>7</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>8-12-98</i>
9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR: Months <i>61</i> Days <i>30</i> Hours <i>30</i> Min <i>30</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Admin. Ass't.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Admin. Asst. U.S. Dept of Agric.</i>	
11. BIRTHPLACE (State or foreign country) <i>Amer. Ill.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>William Ebertz</i>		14. MOTHER'S MAIDEN NAME <i>Mary Kirschel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Abdominal adenocarcinoma</i> <i>199.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>metastatic</i> (c) <i>pleural adenocarcinoma</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>metastatic pleural adenocarcinoma</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 20</i> , 19 <i>59</i> , to <i>Sept 7</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Sept 6</i> , 19 <i>59</i> , and that death occurred at <i>4:30</i> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>900-17th St. W Washington DC</i> DATE SIGNED			
ACTUAL SIGNATURE <i>George William Ware</i>		M.D. <i>George William Ware</i>	
PHYSICIAN'S NAME (Type) <i>GEORGE WILLIAM WARE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>9/10/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MARYLAND</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC. Raymond A. Ziska</i>		24. REC'D BY REGISTRAR <i>SEP 9 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Howard</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
#1  
#2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10414

10371

Reg. Dist. No.

10414

CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Maryland b. COUNTY Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs, Md c. LENGTH OF STAY IN 1b 9 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Philmena rest home

1. d. STREET ADDRESS 417 Windsor St e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) *Winfred H. Dobrin* 4. DATE OF DEATH Month Sept 18, 1959 Day Year

5. SEX female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH Oct 10, 1879 9. AGE (In years last birthday) 79 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY own home 11. BIRTHPLACE (State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME James C. Higgins 14. MOTHER'S MAIDEN NAME Mary J. Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Marie D Mc Callam Address Silver Springs, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) *Cerebrovascular Accident*  
443X DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) *Hypertensive Arteriosclerotic Disease* approx 25 yrs.  
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21 I certify that I attended the deceased from 9-11-1959 to 9-18-1959 that I last saw the deceased alive on 9-18-1959 and that death occurred at 5:15 PM, from the causes and on the date stated above.  
ADDRESS (Street, city or town, state) DATE SIGNED  
ACTUAL SIGNATURE *Harry J. Kichen* M. D. 10620 Georgia Ave 9/18/59  
PHYSICIAN'S NAME (Type) Silver Spring, Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/21/59 22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery 22d. LOCATION (City, town, or county) (State) Washington D. C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Md. 24a. REC'D BY REGISTRAR DATE SEP 21 '59 24b. REGISTRAR'S SIGNATURE *Arthur E. Kious*

VS A15 (4)  
15M 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

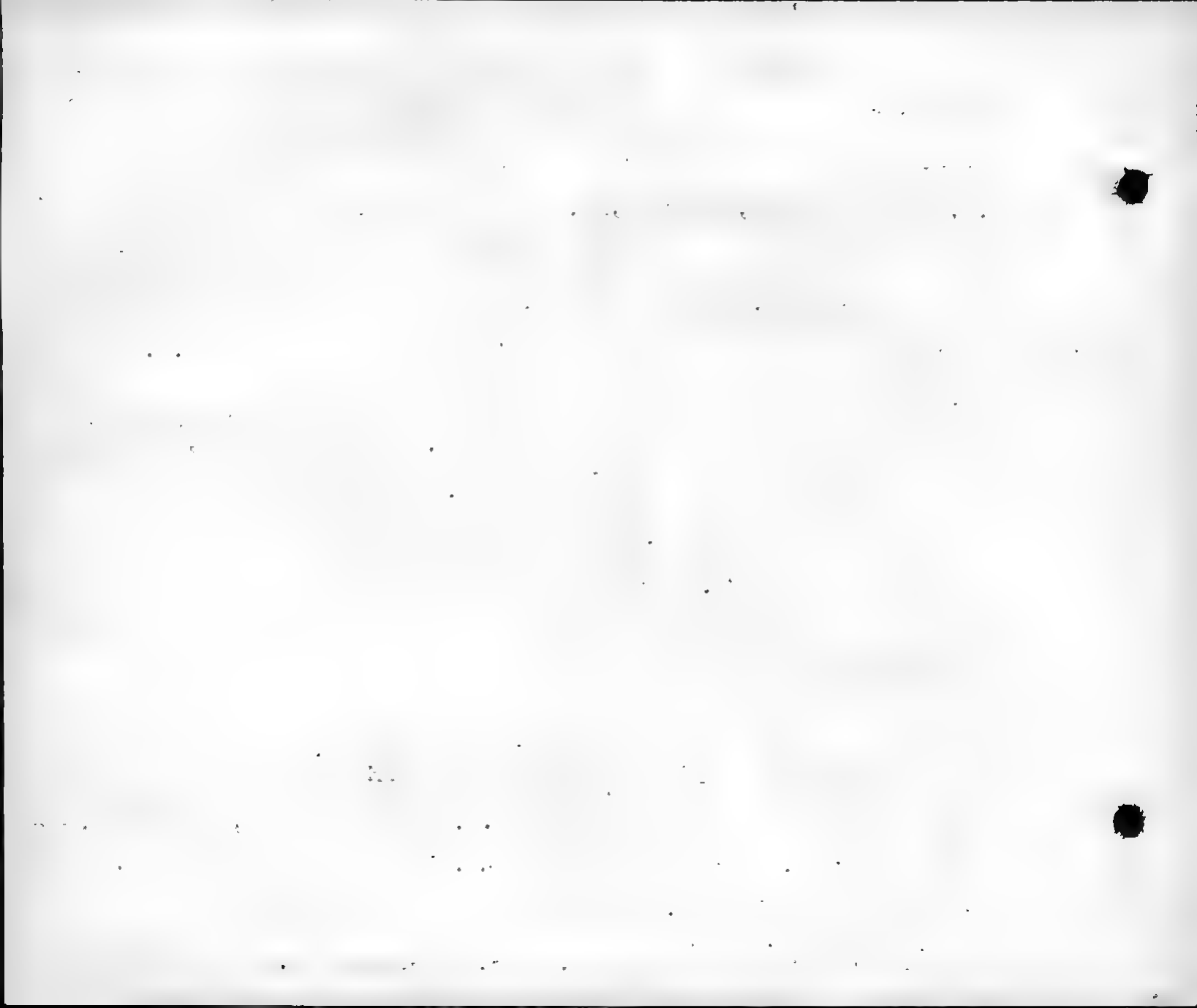
10372

10415

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, If institution. Residence before admission) a. STATE <b>Indiana</b> b. COUNTY <input checked="" type="checkbox"/>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>18 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carl Ernest DOOLEY</b>		4. DATE OF DEATH Month Day Year <b>September 6 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>14 April 1916</b>
9. AGE (In years last birthday) <b>43</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Florist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>k</b>	
11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Isom DOOLEY</b>		14. MOTHER'S MAIDEN NAME <b>Lola TURNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>311 Courtney Drive</b> <b>William H. RAFFEL Triangle, Virginia</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Insufficiency</b> DUE TO <b>Hepatic Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Alcoholism</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 August, 19 59</b> to <b>6 Sept. 19 59</b> that I last saw the deceased alive on <b>6 September, 19 59</b> , and that death occurred at <b>4:40 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 9-7-59</b>			
ACTUAL SIGNATURE <b>William P. Baker</b>		FISICIAN'S NAME (Type) <b>William P. BAKER LT MC USN</b> <b>U.S. Naval Hospital, Bethesda Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 9/8/59</b>		22b. DATE THEREOF <b>Garland Brook</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Columbus Indiana</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest W. Adams</b> <b>Adams Funeral Home 4748 Wisconsin Ave. N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Knead</b>	
24b. REGISTRAR'S SIGNATURE			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10416

CERTIFICATE OF DEATH

10373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>16 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althea-Woodland Nursing Home</u>				e. STREET ADDRESS <u>3608 9th St. So.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mae</u> Middle <u>Kathlein</u> Last <u>Dorn</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 30, 1898</u>	
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Cervid</u>				14. MOTHER'S MAIDEN NAME <u>Kathlein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Edward Dorn</u> Address <u>5307 S.D. Ave. N.E. Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO <u>  </u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral infarct</u> DUE TO <u>  </u>							
(c) <u>Cerebral thrombosis</u> DUE TO <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>Sept. 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 22</u> , 19 <u>59</u> , and that death occurred at <u>2:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman H. Rubenstein</u>				ADDRESS (Street, city or town, state) <u>6480 New Hampshire Ave. M.D.</u>			
DATE SIGNED <u>  </u>							
PHYSICIAN'S NAME (Type) <u>Norman H. Rubenstein M.D.</u>				ADDRESS <u>Takoma Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>9/25/1959</u>		<u>Cedar Hill Cemetery</u>		<u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier Md.</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
DATE <u>SEP 28 '59</u>							

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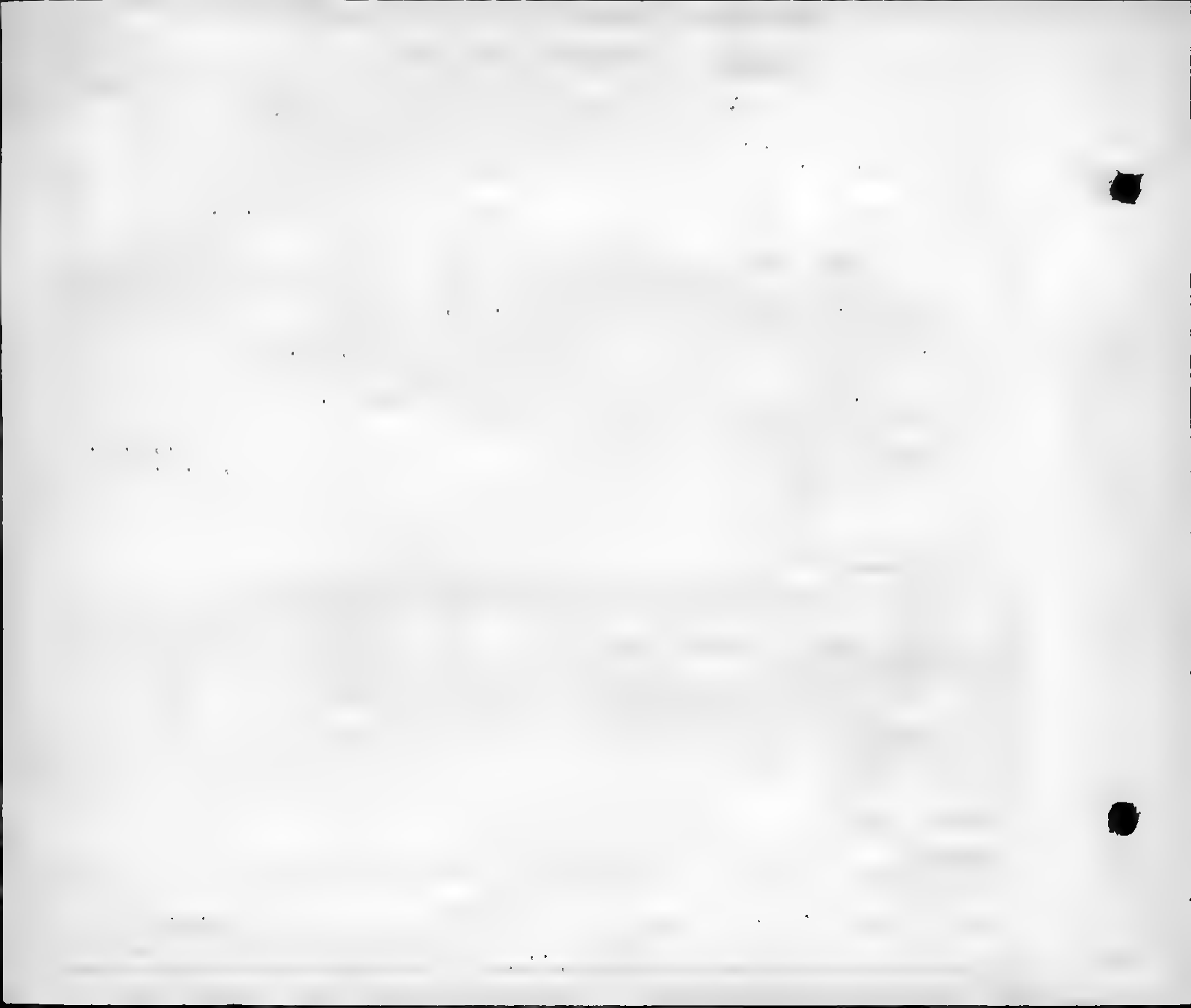
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington, Md.</b> c. LENGTH OF STAY IN 1b <b>Carroll Hall Nursing Home</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Nursing Home</b>				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>472</b> d. STREET ADDRESS <b>3725 Macomb Street, N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EVA</b> Middle <b>STIDHAM</b> Last <b>DOUGALL</b>				4. DATE OF DEATH Month <b>September</b> Day <b>12</b> Year <b>1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1876</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George K. Stidham</b>			14. MOTHER'S MAIDEN NAME <b>Hannah M. Gardiner</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>3725 Macomb St., N. W.</b> <b>Washington, D. C.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>1400.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC MYOCARDITIS</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Sept 7</b> , 19 <b>57</b> , to <b>Sept 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 12</b> , 19 <b>59</b> , and that death occurred at <b>5:30</b> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Washington, D. C.</b> DATE SIGNED <b>Sept 14 1959</b> ACTUAL SIGNATURE <b>Thompson Loring</b> M.D. <b>2206</b> PHYSICIAN'S NAME (Type) <b>Thompson Loring</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 12, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. P. Dues</b>		ADDRESS <b>2847 Wilson Blvd. Arlington, Va.</b>	24a. REC'D BY REGISTRAR <b>SEP 14 59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



b. COUNTY

ON A FARM?  
YES ☐ NO ☐

195-9  
FD-36 (Rev. 5-22-64)

Hours	Min
-------	-----

HSA

Mary Jane ~~Frank~~ FRANK

Address

INTERVAL BETWEEN  
ONSET AND DEATH

2 days

П. А. С.

7 days

5425.

19 WAS ALTITUDE  
PERFORMED?  
YES ☐ NO ☐

19 ~~WAS~~ ALTOPS  
PERFORMED?  
YES ☐ NO ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

{County}

ADDRESS (Street, city or town, state) DATE SIGNED

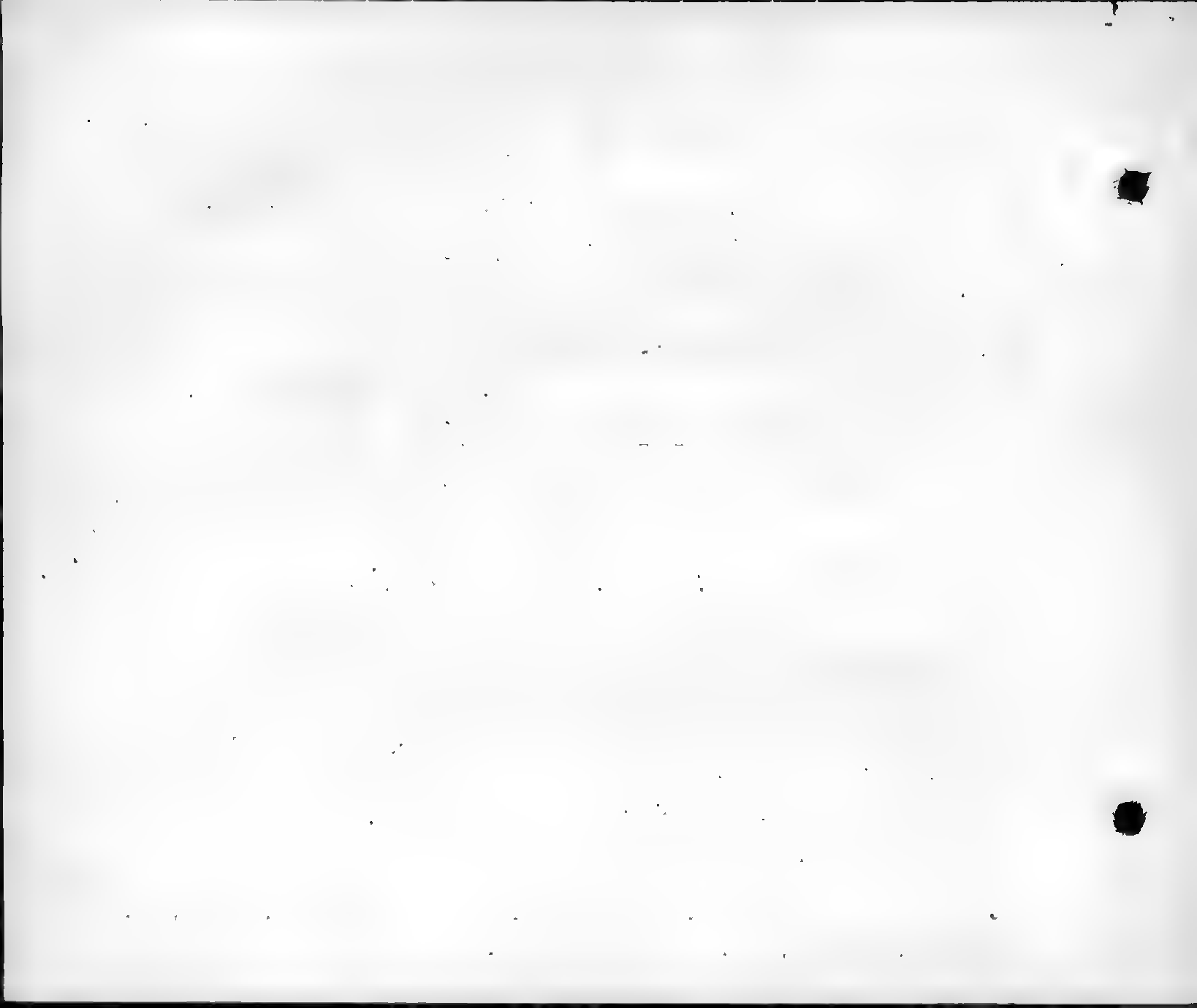
1-59

Takoma Park Ind

22d. LOCATION (City, town or county)  
PRINCE GEO. COUNTY

SILVER SPRING, MD.

24b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

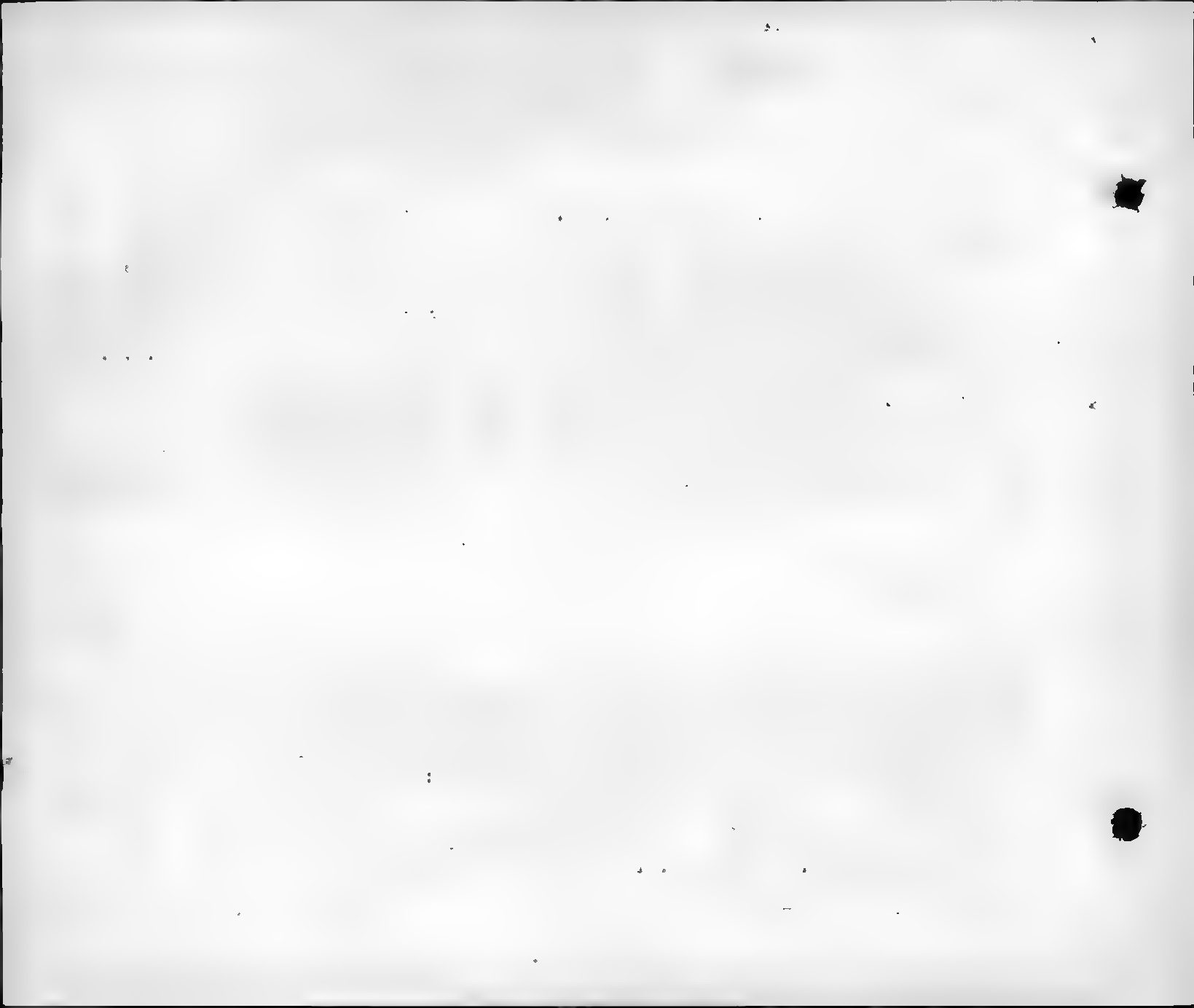
10418

## CERTIFICATE OF DEATH

Reg. Dist. No.

10376

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>24 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Cincinnati</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cincinnati</b> d. STREET ADDRESS <b>1912 State Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sandra</b> Middle <b>Marie</b> Last <b>Eckstein</b>		4. DATE OF DEATH Month <b>September</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 6, 1939</b>
9. AGE (In years last birthday) <b>19</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Communications</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph E. Eckstein</b>		14. MOTHER'S MAIDEN NAME <b>Valda Stephens</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b> <b>6 Months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 24, 1959</b> , to <b>September 17, 1959</b> , that I last saw the deceased alive on <b>September 17, 1959</b> , and that death occurred at <b>7:42 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>9/17/59</b>			
ACTUAL SIGNATURE <b>Arthur R. Rothman MD</b>		PHYSICIAN'S NAME (Type) <b>ARTHUR R. ROTHMAN, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL <b>Transit</b>		22b. DATE THEREOF <b>9-18-59</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Cincinnati, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Clifford B. Fries</b>	





10352

## CERTIFICATE OF DEATH

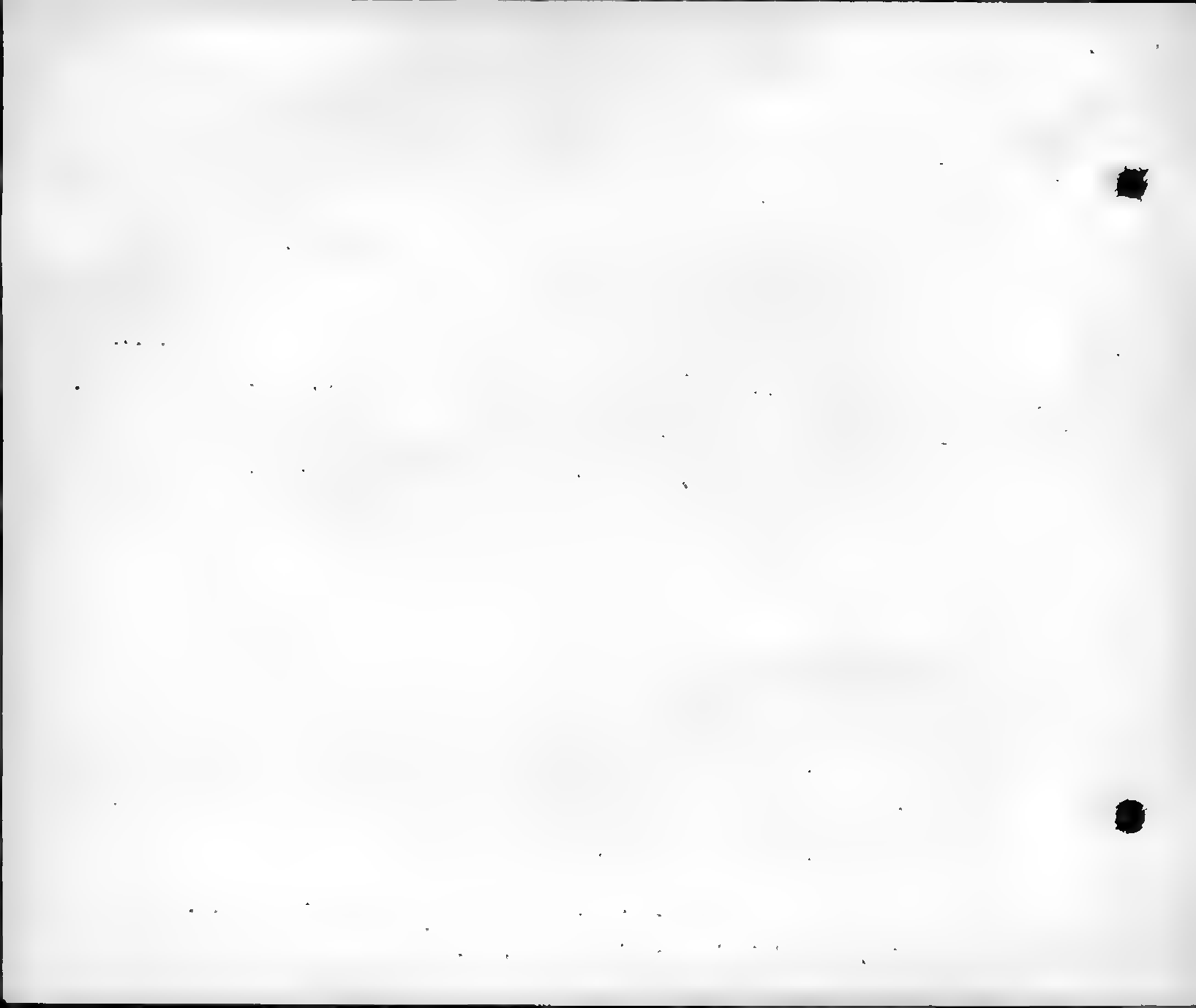
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>17 TAKOMA PARK 12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN &amp; HOSP</b>		d. STREET ADDRESS <b>10026 TENBROOK DRIVE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLAIRE CHRISTINE EGGERS</b>		4. DATE OF DEATH <b>7 43 AM 9 - 3 - 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-2-59</b>
9. AGE (In years last birthday) yrs <b>16 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE H. EGGERS</b>		14. MOTHER'S MAIDEN NAME <b>MARY FRANCIE XXXXXXXX GUY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <b>INFORMANT</b> Address <b>HOSP RECORDS WASH. SAN.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DIAPHRAGMATIC HERNIA</b> <b>560.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>10 HRS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/21</b> , 19 <b>59</b> , to <b>9/3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9/3</b> , 19 <b>59</b> , and that death occurred at <b>7 A</b> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Stanley L. Blumenthal</b> M.D.		ADDRESS (Street, city or town, state) <b>10620 GEORGIA AVE, SILVER SPRING, MD</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>STANLEY L. BLUMENTHAL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9/8/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR <b>SILVER SPRING, MD.</b> DATE <b>SEP 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

2075353XV7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



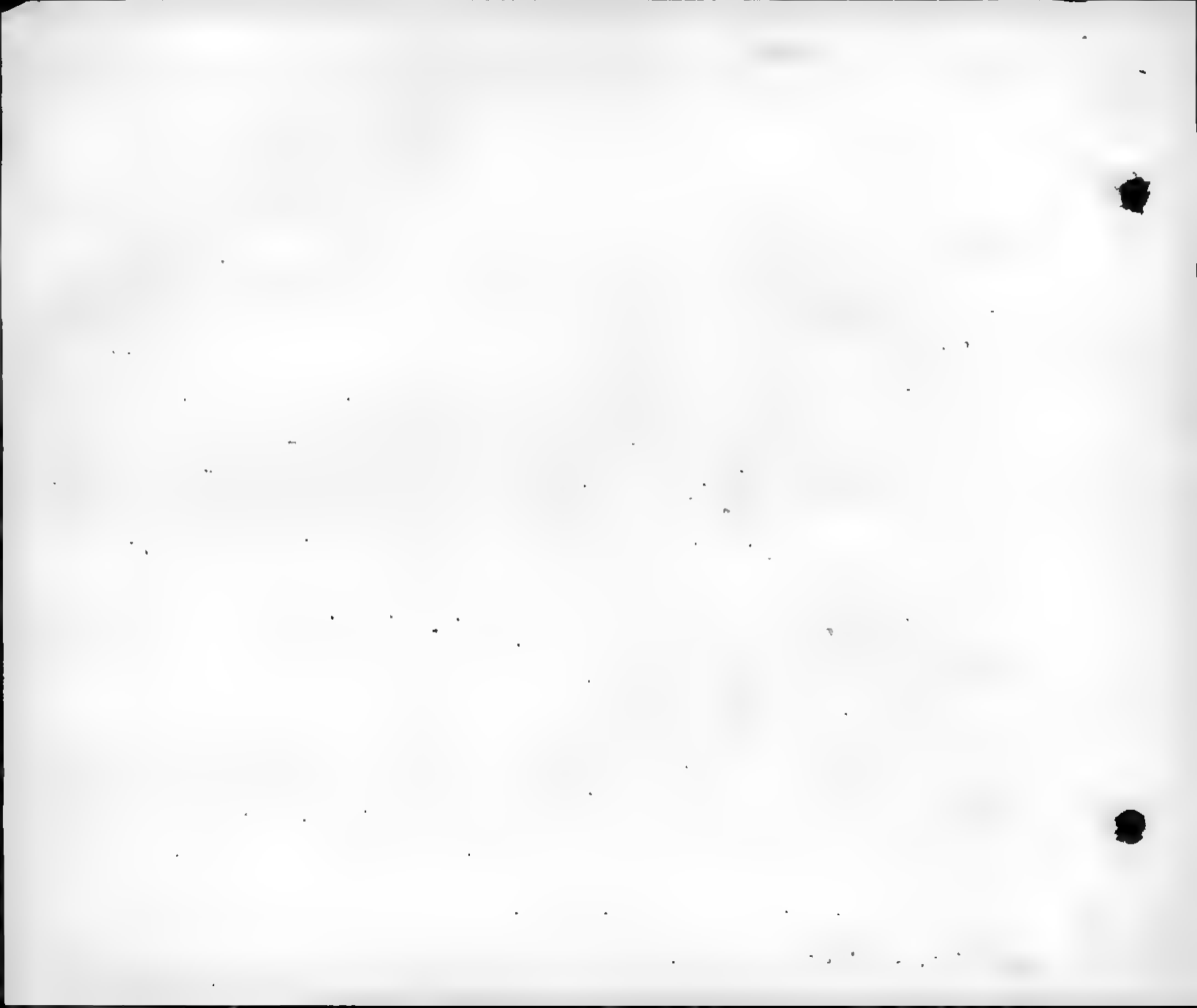
10419

## CERTIFICATE OF DEATH

Reg. Dist. No. 10378

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4514 Amherst Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>Eiseman</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/23/97</u>	
9. AGE (In years, last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>6</u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Consultant</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Gilbert M. Eiseman</u>				14. MOTHER'S MAIDEN NAME <u>Areli S. <del>Hartson</del> Hartson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Army</u>				16. SOCIAL SECURITY NO <u>218-38-7931</u>			
17. INFORMANT <u>Ada H Eiseman-wife-same as 2d</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion Anterior Circumflex</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Postoperative Myocardial Infarction, Left Ventricular</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month <u>None</u> Day <u>None</u> Year <u>None</u> Hour a. m. <u>None</u> p. m. <u>None</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>9/12, 1959</u> , to <u>9/29, 1959</u> , that I last saw the deceased alive on <u>9/29</u> , 19 <u>59</u> , and that death occurred at <u>10:55</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John B. Umhan</u> M.D.				ADDRESS (Street, city or town, state) <u>8805 Conn. Ave.</u> DATE SIGNED <u>9/29/59</u>			
PHYSICIAN'S NAME (Type) <u>John Umhan</u>				<u>Chas. Chase 15 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kimes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

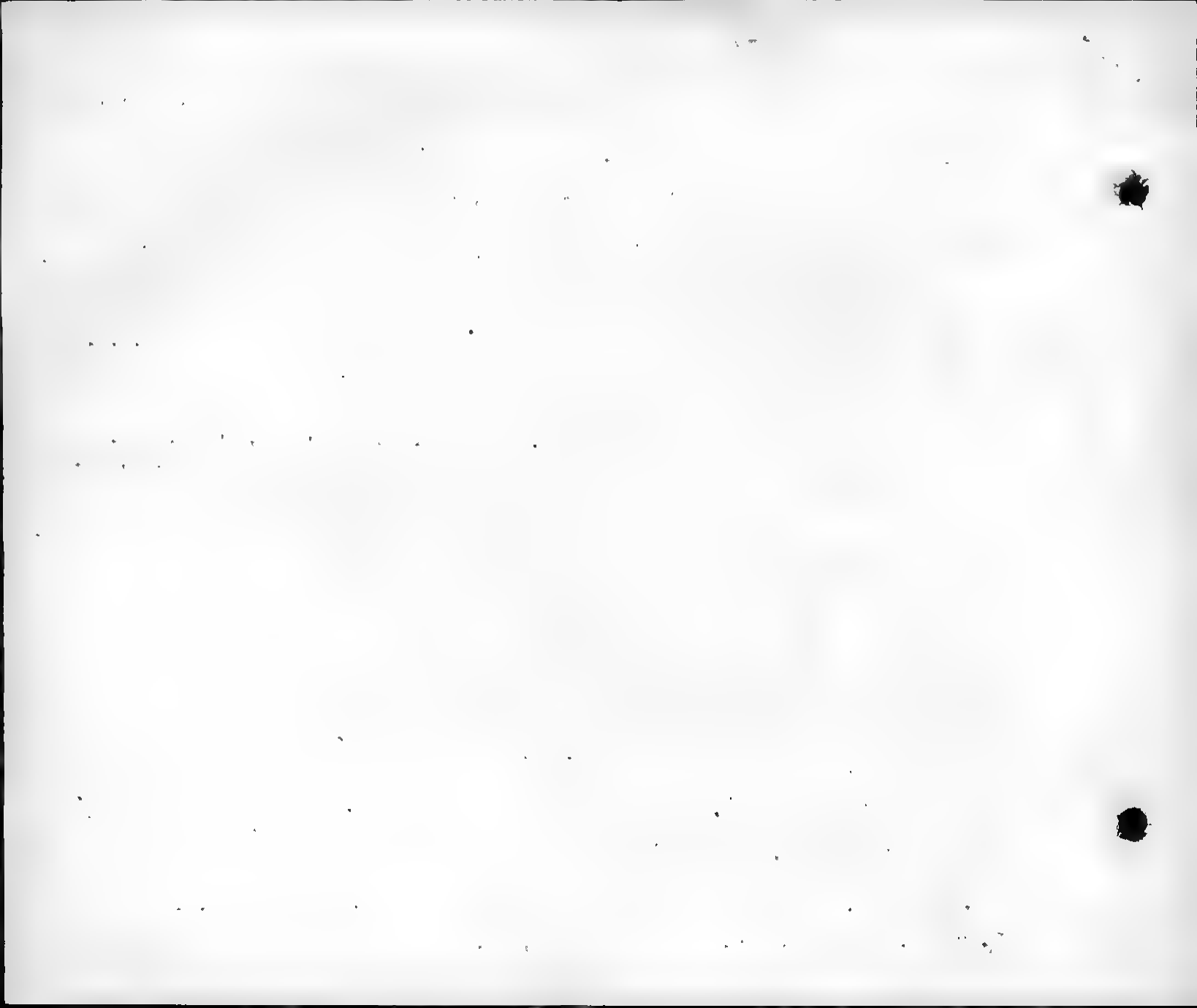
10420

CERTIFICATE OF DEATH

Reg. Dist. No. 10379

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Nursing Home</b>		e. STREET ADDRESS <b>11,610 GEORGIA AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>MARIA</b> Last <b>Eagling</b>		4. DATE OF DEATH Month <b>9</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec-28-1878</b>	9. AGE (In years last birthday) <b>80</b> yrs	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ALFRED FISCHER</b>		14. MOTHER'S MAIDEN NAME <b>SUZANNE PHILLIPS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. ADDRESS <b>Mrs. Marion E. Jacobsen, 11,610 Ga. Ave. Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Lobar Pneumonia</b> DUE TO (b) <b>Leucoblastic arteriosclerosis</b> DUE TO (c) <b>24 hours</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 5, 1959</b> , to <b>Sept 7, 1959</b> ; that I last saw the deceased alive on <b>Sept 7, 1959</b> , and that death occurred at <b>2:05 PM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Michael M. Doebridge</b>		DATE <b>Sept 7, 1959</b>			
PHYSICIAN'S NAME (Type) <b>MICHAEL M. DOEBRIDGE</b>		ADDRESS (Street, city or town, state) <b>Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. POMPHREY, INC.</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>SEP 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Raymond A. Ziska</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

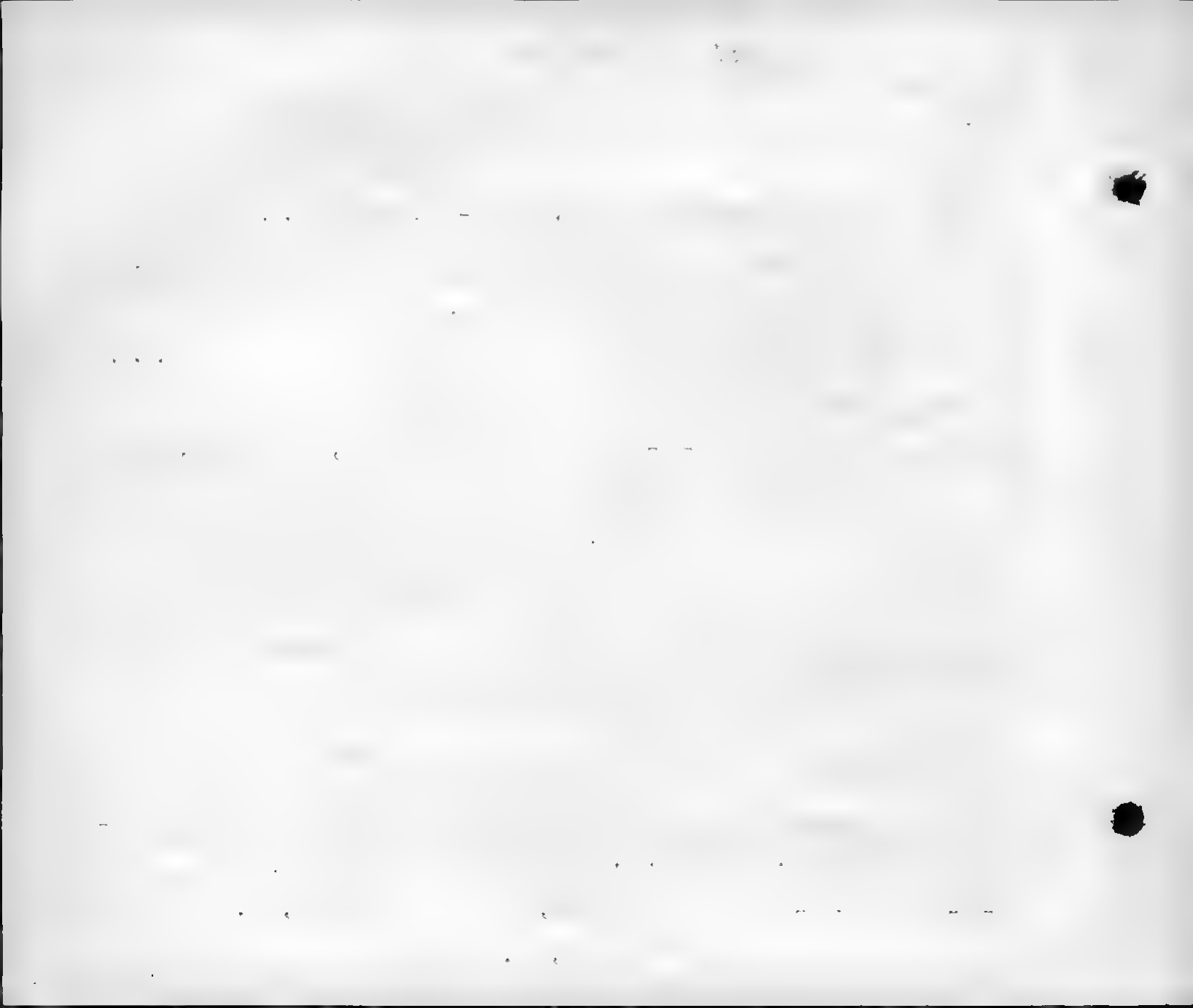
10421

## CERTIFICATE OF DEATH

Reg. Dist. No.

10380

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admision) a. STATE <b>District of Columbia</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>9 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>906 - 3rd Street, S.E.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Richard</b> Last <b>English</b>				4. DATE OF DEATH Month <b>September</b> Day <b>6</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>May 14, 1919</b>	
9. AGE (In years last birthday) <b>40 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurses Aide</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Robert English</b>			
14. MOTHER'S MAIDEN NAME <b>Annie Tinsley</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>			
16. SOCIAL SECURITY NO. <b>223-12-0600</b>				17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Failure 20</b> DUE TO <b>199.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Memo generic medicine</b> DUE TO <b>Adrenal insufficiency</b> (c) <b>20</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 28</b> , 19 <b>59</b> , to <b>September 6</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>September 6</b> , 19 <b>59</b> , and that death occurred at <b>2:05 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>9-7-59</b> ACTUAL SIGNATURE <b>Charles E. Mengel</b> PHYSICIAN'S NAME (Type) <b>Charles E. Mengel, M. D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-11-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New River,</b>		22d. LOCATION (City, town, or county) (State) <b>Pulaski, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Juondin</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 10 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hand</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

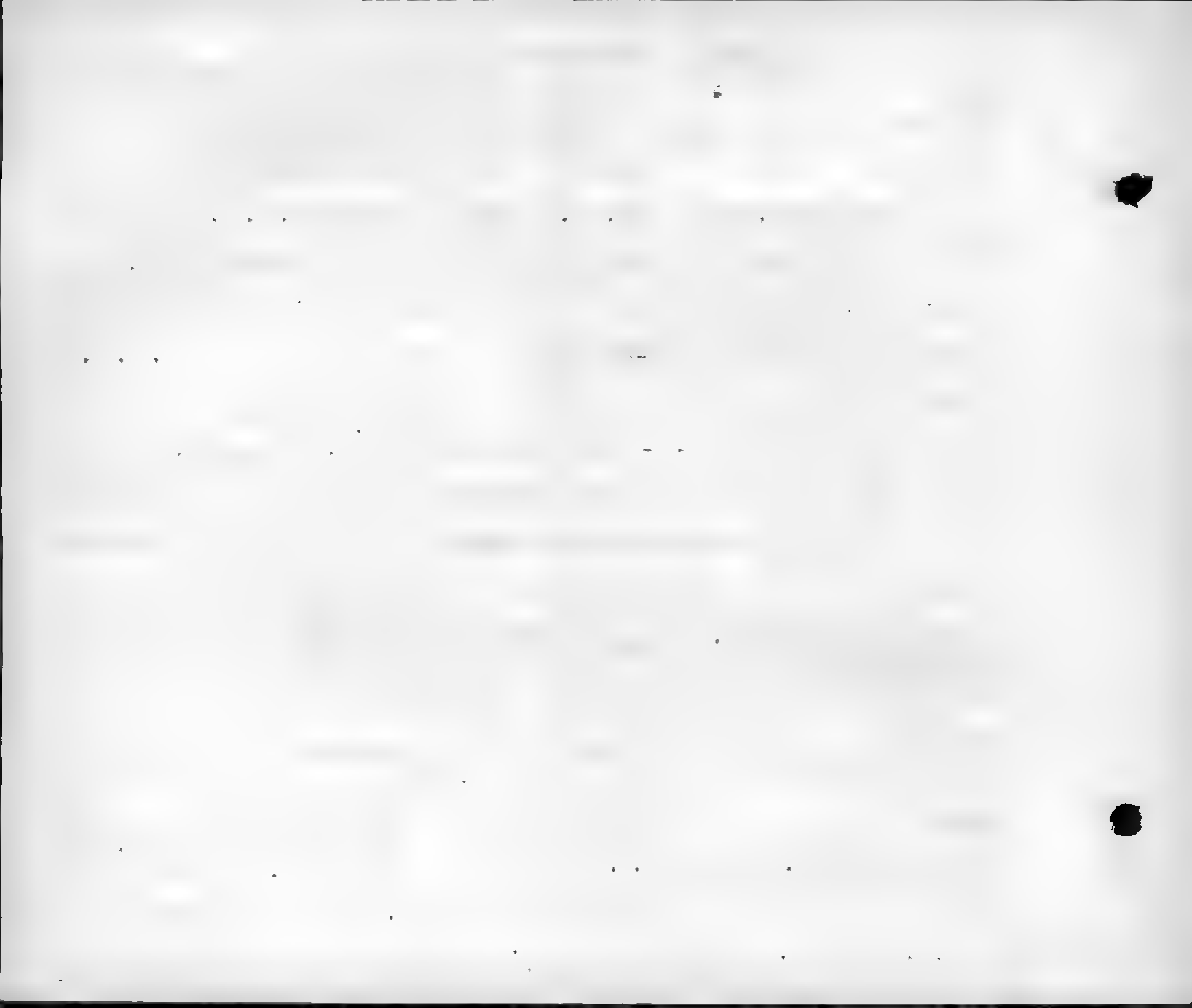
10422

## CERTIFICATE OF DEATH

Reg. Dist. No.

10381

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>88 days</b> d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>The District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4</b> d. STREET ADDRESS <b>5310 Chillum Place, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>Irene</b> Last <b>Farrah</b>		4. DATE OF DEATH Month <b>September</b> Day <b>25</b> Year <b>1959</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 23, 1916</b>		9. AGE (In years last birthday) yrs. <b>43</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>25</b> Hours <b>19</b> Min <b>59</b>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housewife &amp; Cashier</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Gateway Coffee Shop</b>				11. BIRTHPLACE (State or foreign country) <b>Missouri</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>											
13. FATHER'S NAME <b>Charles Ketchum</b>				14. MOTHER'S MAIDEN NAME <b>Elsie Hendricks</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>498-16-8589</b>				17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gas Gangrene of Bowel, Liver, with Clostridium Septicemia</b>												INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>											
												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 29, 1959</b> to <b>September 25, 1959</b> , that I last saw the deceased alive on <b>September 25, 1959</b> , and that death occurred at <b>10:00 P. M.</b> from the causes and on the date stated above.																							
ACTUAL SIGNATURE <b>Richard C. Mechanic</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b>				DATE SIGNED <b>9/26/59</b>				PHYSICIAN'S NAME (Type) <b>RICHARD C. MECHANIC, M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9/29/59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>				22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>											
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>								ADDRESS <b>2901 14th St. N.W.</b>				24a. REC'D BY REGISTRAR <b>SEP 28 '59</b>				24b. REGISTRAR'S SIGNATURE <b>C. L. H. Hines</b>							



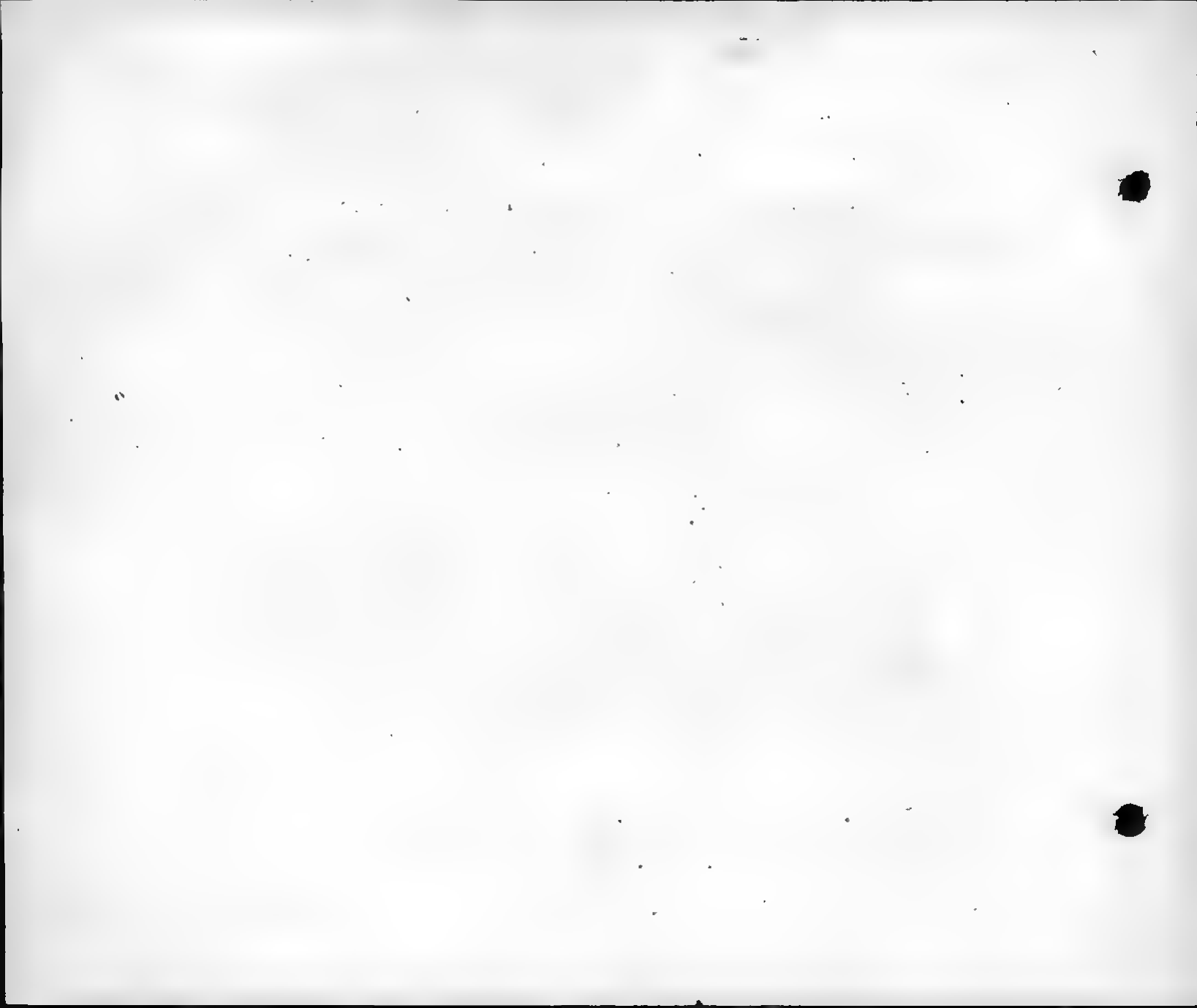
10382

Reg. Dist. No.

**§ 263.10 TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

**REGISTRAR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 hrs. 50 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Kensington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>11112 Lund Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rose</b>		First <b>C</b>		Middle <b>Fitzgerald</b>		Last <b>September 17</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/9/88</b>	
9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Mass</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick</b>		13. FATHER'S NAME <b>Cronan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Moffitt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>019-14-5402</b>		INFORMANT <b>Mrs. Norman E. Hall</b>		Address <b>11112 Lund Pl</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central Right Side Heart Failure, Cor Pulmonale</b> DUE TO <b>Chronic Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Hypertension</b> DUE TO <b>Chronic Hypertension</b> (c) <b>Chronic Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>59</b> , to <b>Sept 17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 17</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>10511 Summit Ave</b>		DATE SIGNED <b>Sept 18, 1959</b>			
ACTUAL SIGNATURE <b>George Sharpe M.D.</b>		M.D. <b>10511 Summit Ave</b>					
PHYSICIAN'S NAME (Type) <b>George Sharpe, M.D.</b>							
22a. BURIAL CREMATION <b>Burial</b>		22b. DATE THEREOF <b>9/18/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks</b>		22d. LOCATION (City, town, or county) (State) <b>Fall River, Massachusetts</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>...</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10353

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10383

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>			
b. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>				d. STREET ADDRESS <u>2122 California ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ella (N M N) Fleming</u>				4. DATE OF DEATH Month <u>9</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-86</u>		9. AGE (in years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lawyer.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Cornelius Daly</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Donoghue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>579-52-6620</u>		17. INFORMANT <u>Pt's Hosp. Record.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Rt. Sub-arachnoid Hemorrhage</u> 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Fall on floor at home</u> DUE TO (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> 57m							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>F</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall on floor at home</u>					
20c. TIME OF INJURY Hour <u>5:00</u> a.m. <u>9-20</u> p.m. <u>1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Wash-</u> (County) <u>DC</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Blischke</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BLISCHKE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-22-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) <u>Silver Spring, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821-14th ST. N.W. Wash. DC.</u>				24a. REC'D BY REGISTRAR <u>SEP 24 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

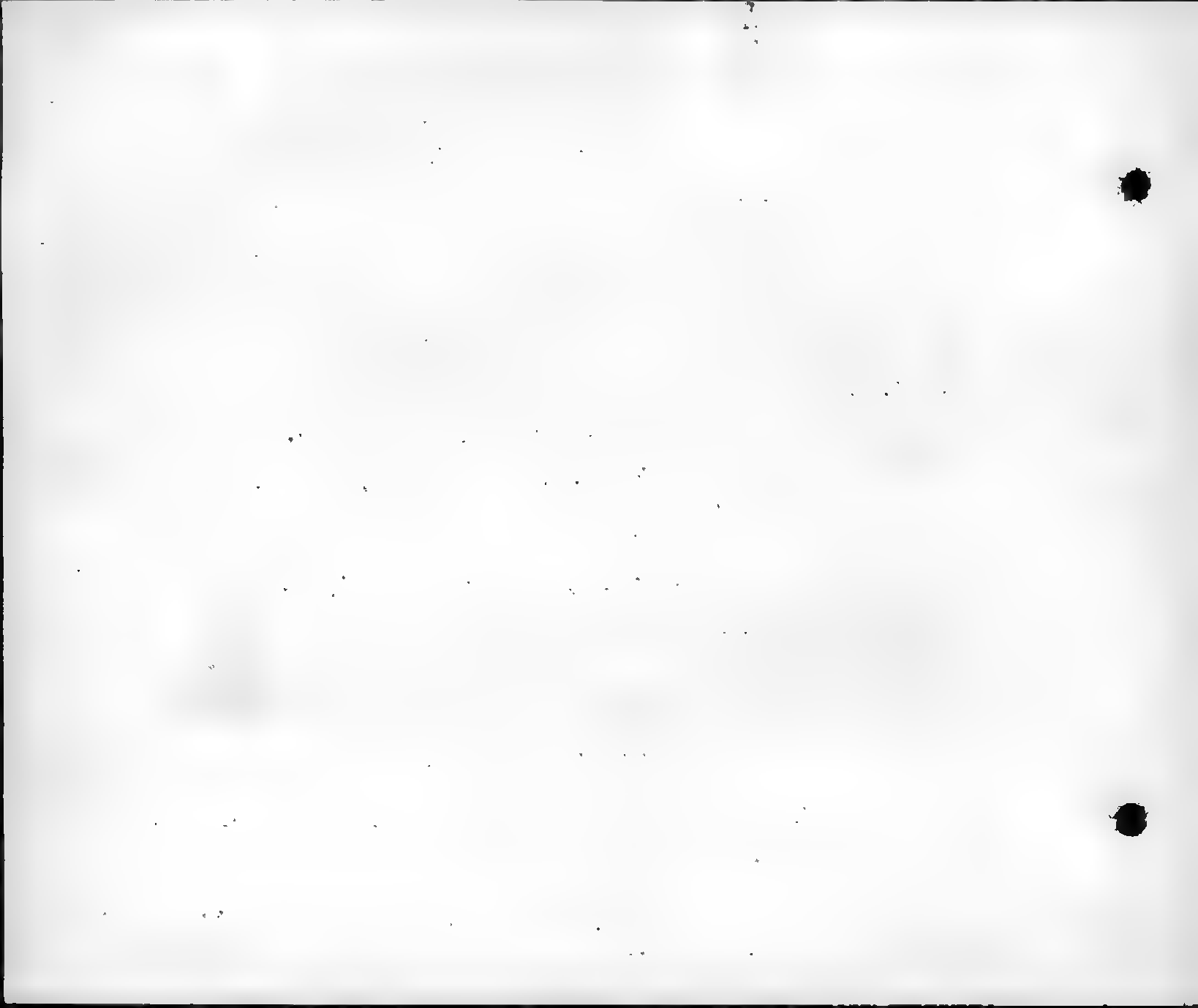
TO FUNERAL DIRECTOR: Page 1 and 2 with the registrar prior to burial, cremation, or removal.



10384

Reg. Dist. No.

1. PLACE OF BIRTH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>4 weeks, 2 days</b> X <b>Gaithersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>1424 Frederick Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Conda</b> Middle <b>L.</b> Last <b>Fletcher</b>		4. DATE OF DEATH Month <b>September</b> Day <b>16,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 31, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lyman C. Fletcher</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Fletcher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Yes 214-18-3374</b>	
17. INFORMANT <b>Nora H. Fletcher (wife)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Bronchopneumonia</b> DUE TO <b>Infection</b> (b) <b>Immature</b> DUE TO <b>Carcinoma of Prostate with Metastases</b> (c) <b>Bilateral Apnephrosis secondary to CA of Prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Apnephrosis secondary to CA of Prostate</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 10</b> , 19 <b>59</b> , to <b>Sept 15</b> , 19 <b>59</b> , and that death occurred at <b>5:40</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1835 Eye Street N.W. (und)</b> DATE SIGNED <b>SEP 18 '59</b> ACTUAL SIGNATURE <b>Herbert A. Goldberg</b> PHYSICIAN'S NAME (Type) <b>Herbert A. Goldberg</b>			
22a. BURIAL, CREMATION, REMQVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/18/59</b>	
22c. NAME OF CEMETERY, OR CREMATORY <b>Piney Plain</b>		22d. LOCATION (City, town, or county) (State) <b>Piney Grove, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. Hanks</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 18 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hanks</b>			





10425

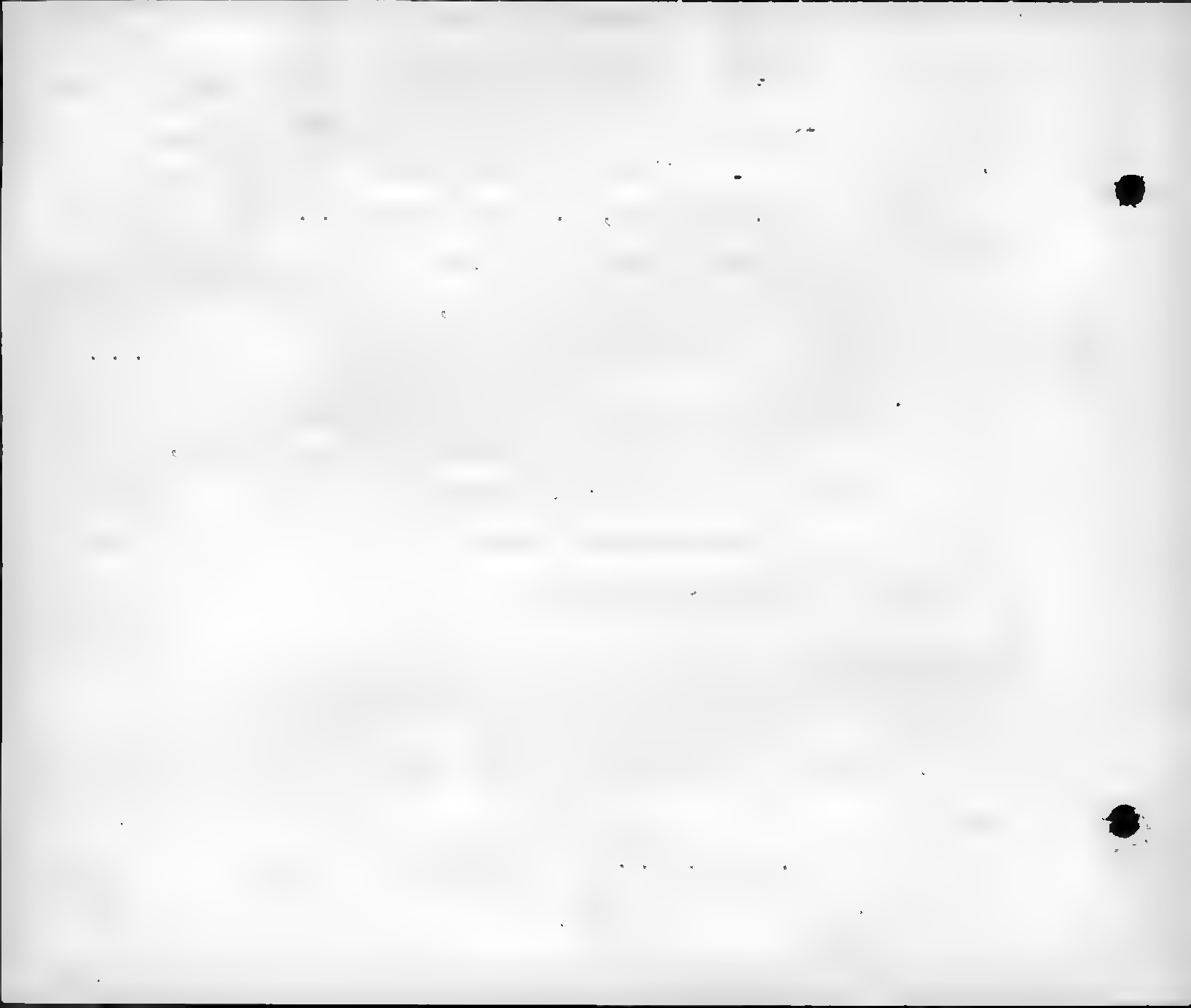
## CERTIFICATE OF DEATH

Reg. Dist. No

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>52 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>1633 L Street, N.W.</b>			
3 NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Orellia</b> Last <b>Fong</b>				4. DATE OF DEATH Month <b>September</b> Day <b>4</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1906</b>	9. AGE (In years lost birthday) yrs. <b>52</b>	10. IF UNDER 1 YEAR Months <b>5</b> Days <b>14</b> Hours <b>59</b>		11. IF UNDER 24 HRS Mn.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Administrative</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
13. FATHER'S NAME <b>David M. Gardiner</b>				14. MOTHER'S MAIDEN NAME <b>Florence Stinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Bilateral</b>							<b>3 days</b>
203x DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>Poor Respiratory Excursion</b>							<b>2 months</b>
DUE TO							
(c) <b>Multiple Myeloma</b>							<b>15 months</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>July 14, 19 59</b> , to <b>September 4, 19 59</b> , that I last saw the deceased alive on <b>September 4, 19 59</b> , and that death occurred at <b>1:45 A.M.</b> , from the causes and on the date stated above							
ADDRESS (Street, city or town, state) <b>Bethesda 14, Maryland</b> DATE SIGNED <b>9/4/59</b>							
ACTUAL SIGNATURE <b>Charles E. Mengel</b> M.D.				National Institutes of Health			
PHYSICIAN'S NAME (Type) <b>CHARLES E. MENGEL, M.D.</b>				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)	
<b>BURIAL SEPT-6-59</b>		<b>SEPT-6-59</b>		<b>GEORGE WASHINGTON</b>		<b>RIGGS RD, M.D.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers, Jr.</b>				ADDRESS <b>1400 Capital St.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 8 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film 6249 9-28-59 et

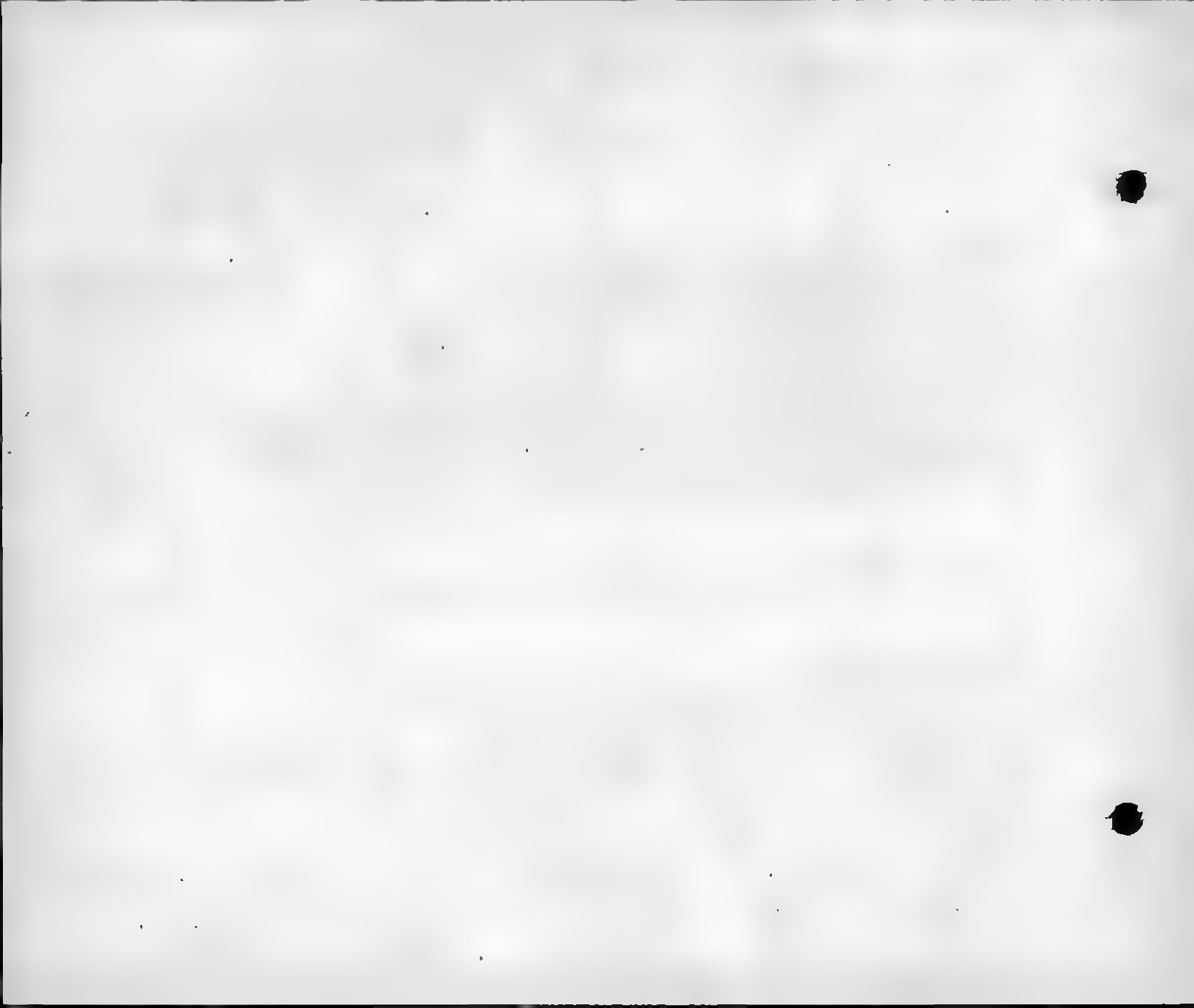
Reg. Dist. No.

10426

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD # 1, Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD # 1, Silver Spring</b>	
c. LENGTH OF STAY IN 1b <b>3 yrs</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Everest Care Home</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>Mt. Everest Care Home</b>	
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Ford</b> Last <b>Ford</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/30/72</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR Months <b>87</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Mt. Everest Care Home, Silver Spring Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>A</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>9/22/59</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Beallsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Niles</b>		24a. REC'D BY REGISTRAR <b>SEP 24 59</b>	
ADDRESS <b>Damascus, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles A. Kline</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

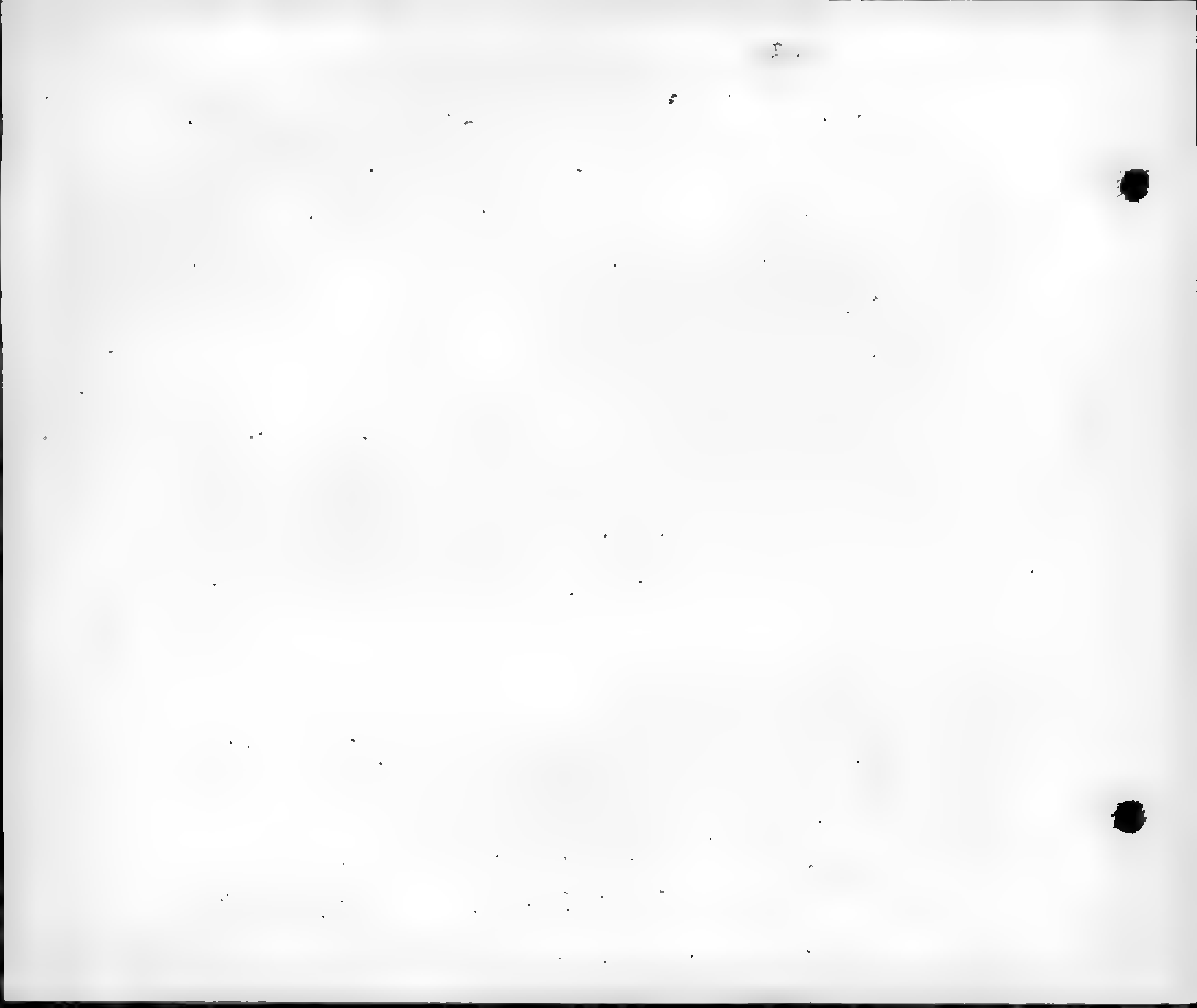


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

Dr. Brochart Notified

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
10427					CERTIFICATE OF DEATH						
Reg. Dist. No. 10387											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>17 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>					d. STREET ADDRESS <u>733 Anderson Ave.</u>						
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>A.</u> Last <u>Foster</u>					4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>19 59</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/19/90</u>		9. AGE (In years last birthday) <u>69</u> yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
13. FATHER'S NAME <u>Samuel Lentz</u>					14. MOTHER'S MAIDEN NAME <u>Minnie, Adelaide Lent Mathews</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>			16. SOCIAL SECURITY NO <u>(If yes, give war or dates of service)</u>		INFORMANT Address <u>William J. Foster, Gaithersburg, Md</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arterioclosis</u> DUE TO (c) <u>Auricular Tachycardia; Congestive Heart Failure</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Sept 26, 1959</u> to <u>Sept 27, 1959</u> , that I last saw the deceased alive on <u>Sept 26, 1959</u> , and that death occurred at <u>5:40 A</u> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>James W. Egan</u> M.D.					ADDRESS (Street, city or town, state) DATE SIGNED						
PHYSICIAN'S NAME (Type) <u>James W. Egan</u>					7720 Wisconsin Ave. Bethesda						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg</u> <u>Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur C. Gaithersburg</u>					ADDRESS <u>100</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur C. Gaithersburg</u>		



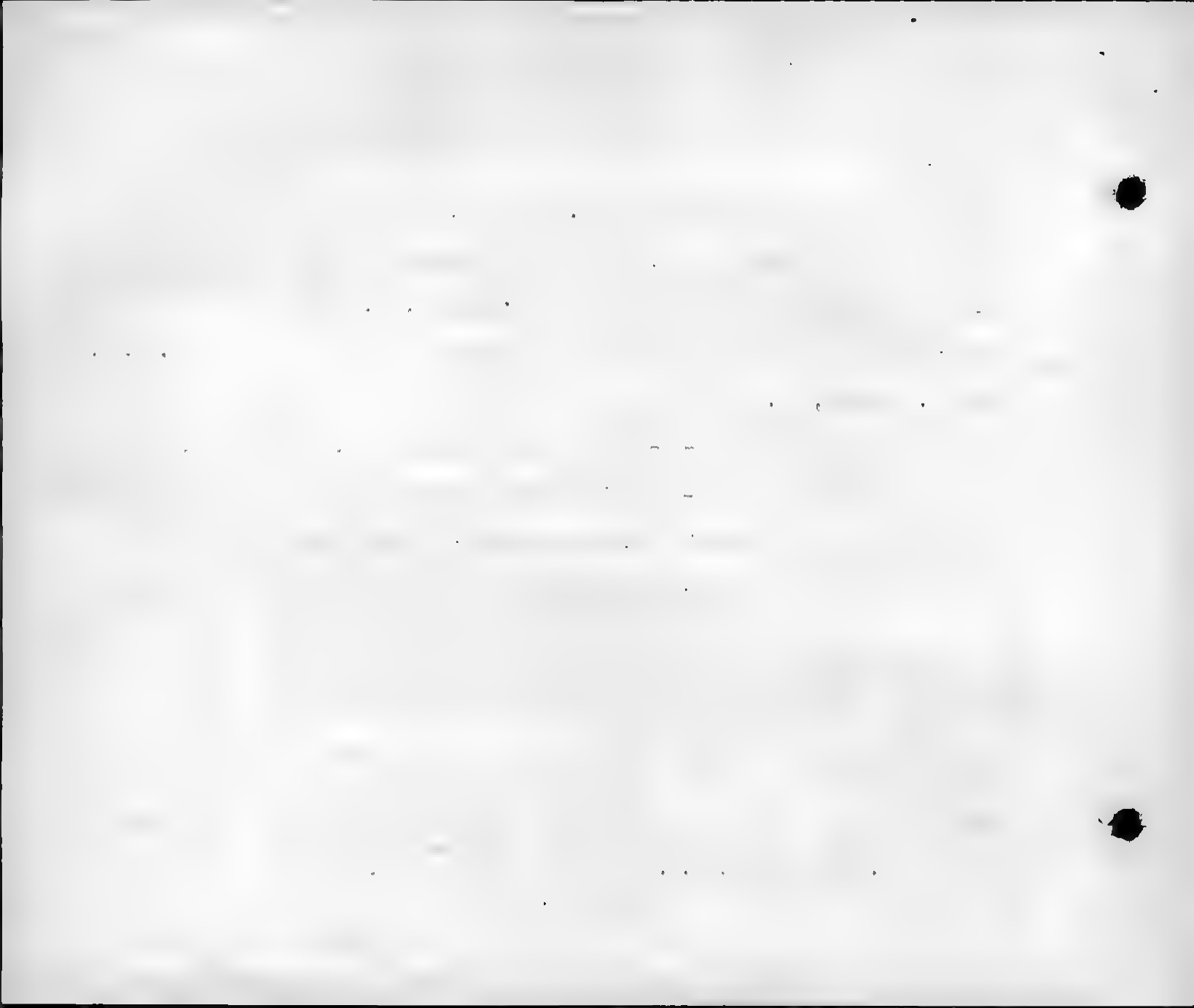
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or inhumation, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10428**      **CERTIFICATE OF DEATH**

10388

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>	
c. LENGTH OF STAY IN 1b <b>6 days</b>		d. STREET ADDRESS <b>1932 Storm Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Larry</b> Middle <b>Edman</b> Last <b>Freeman</b>		4. DATE OF DEATH Month <b>September</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 25, 1941</b>
9. AGE (In years last birthday) <b>17</b> yrs		IF UNDER 1 YEAR: Months <b>12</b> Days <b>19</b> Hours <b>59</b> M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Markets</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John C. Freeman, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Edith Barnes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>239-64-4934</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Post-operative Cardiac Failure</b> <b>754.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Total Anomalous Pulmonary Venous Return</b> DUE TO (c) <b>Atrial Septal Defect</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>Birth</b> <b>Birth</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>September 6, 1959</b> to <b>September 12, 1959</b> , that I last saw the deceased alive on <b>September 12, 1959</b> , and that death occurred at <b>11:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>9/12/59</b>			
ACTUAL SIGNATURE <i>[Signature]</i> M.D.		National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) <b>E. KENT CARNEY, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Buried</b>	<b>9/13/59</b>	<b>Roseboro, N. C.</b>	<b>Roseboro, N. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>		ADDRESS <b>Bethesda, Md.</b>	24a. REC'D BY REGISTRAR <b>SEP 15 59</b>
			24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10429

## CERTIFICATE OF DEATH

Reg. Dist. No.

10389

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2802 Washington Ave. Ch. Ch. Md.</u>		d. STREET ADDRESS <u>2802 Wash. Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>Friedman</u> Last <u>Friedman</u>		4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 15, 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Friedman</u>		14. MOTHER'S MAIDEN NAME <u>Eva Bechik</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT Address <u>Mrs. Hannah Friedman - 2802 Wash. Ave. Ch. Ch. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure</u> 4. 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis + myocardial infarction</u> DUE TO (c) <u>Coronary artery disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>10-15 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>December 1956</u> to <u>Sept 28</u> , 1959, that I last saw the deceased alive on <u>Sept. 27</u> , 1959, and that death occurred at <u>9:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sydney Leventhal, M.D.</u>		ADDRESS (Street, city or town, state) <u>9210 Colson Rd. Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Sydney Leventhal</u>		DATE SIGNED <u>9/28/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 30, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Hillside, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky &amp; Sons</u>		ADDRESS <u>3501-14th St. N.W. Wash. DC</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur B. King</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10390

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Co. Gen. Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7 Takoma Park</u> d. STREET ADDRESS <u>6716 Montgomery Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Frank R. Gaither</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Sept 6 1959</u>		<b>5. SEX</b> <u>Male</u>			
<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-18-1915</u>			
<b>9. AGE</b> (in years last birthday) <u>43</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Electronic equipment</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>MD</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days	Hours Min.						
<b>13. FATHER'S NAME</b> <u>Ernest R. Gaither</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Carmie Bell Murphy</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b> <u>Calvert Hall Silver Spring Md.</u>		<b>17. INFORMANT</b> <u>15711 Columbia Rd.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an <del>Autopsy</del> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>9-6-59</u>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSCHE</u>		<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>					
<b>22b. DATE THEREOF</b> <u>Sept. 9 '59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Immanuel Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Seagoville - Howard Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur S. Krasa</u>		<b>ADDRESS</b> <u>WASH. 12, D.C.</u>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>SEP 9 '59</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Krasa</u>		<b>24c. REGISTRAR'S SIGNATURE</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10431

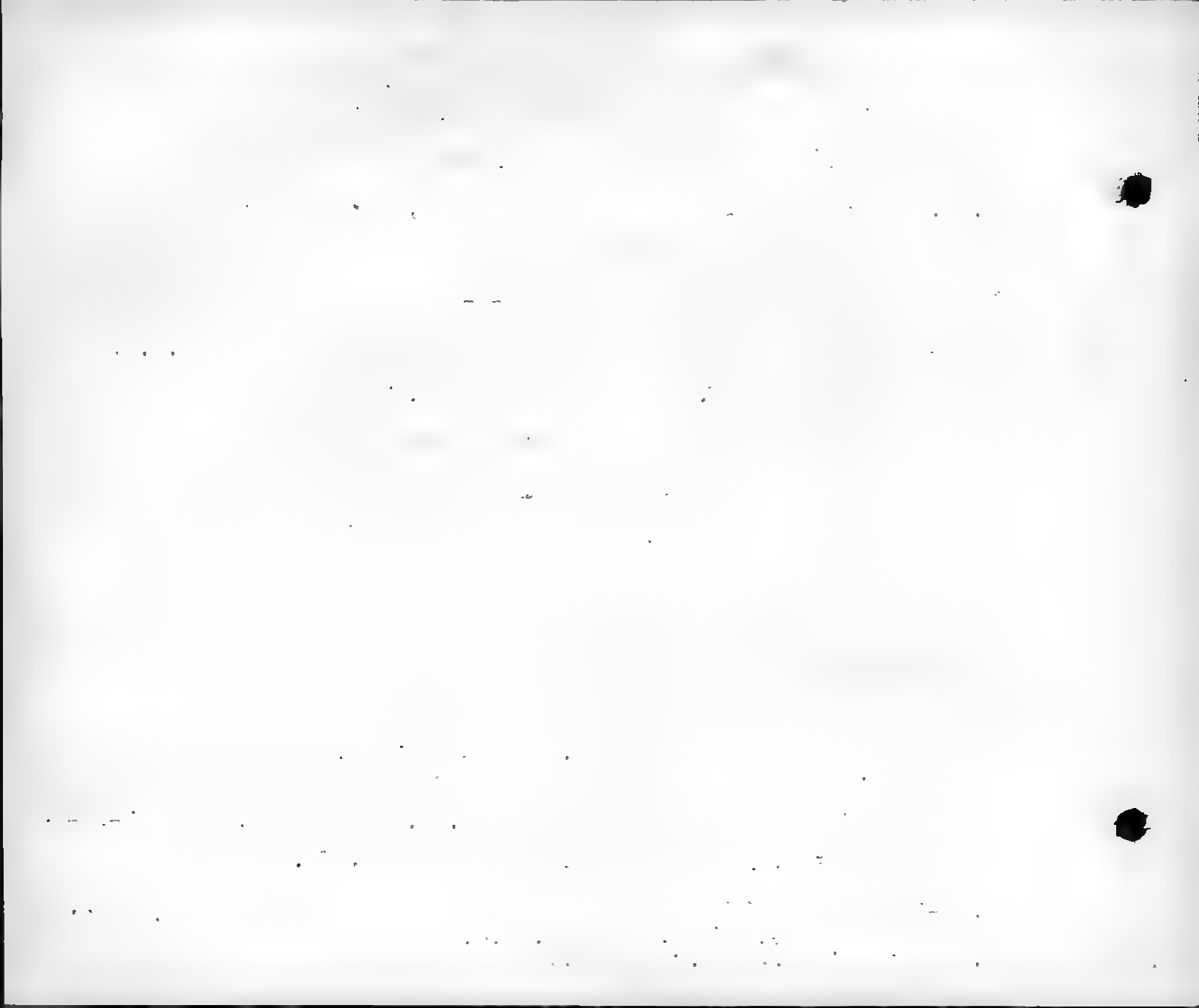
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Elkins</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Box 183, Parsons Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Willard GEYER</b>				4. DATE OF DEATH Month Day Year <b>September 12 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-8-14</b>	
9. AGE (In years last birthday) yrs. <b>45</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>State Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>State</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>	
13. FATHER'S NAME <b>Charles William GEYER</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. WOLF</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service) <b>Yes WWII</b>				16. SOCIAL SECURITY NO. <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>43</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Lymphatic Leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 8, 1959</b> , to <b>Sept. 12, 1959</b> , that I last saw the deceased alive on <b>Sept. 12, 1959</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William P. Baker</b> M.D.				DATE SIGNED <b>9-13-59</b>			
PHYSICIAN'S NAME (Type) <b>William P. BAKER, LT, MC, USN Bethesda, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial-Shipment 9-14-59</b>				<b>Elkins W. Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers &amp; Co., 1400 Chapin St., NW, Wash. D.C.</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <b>SEP 16 '59</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

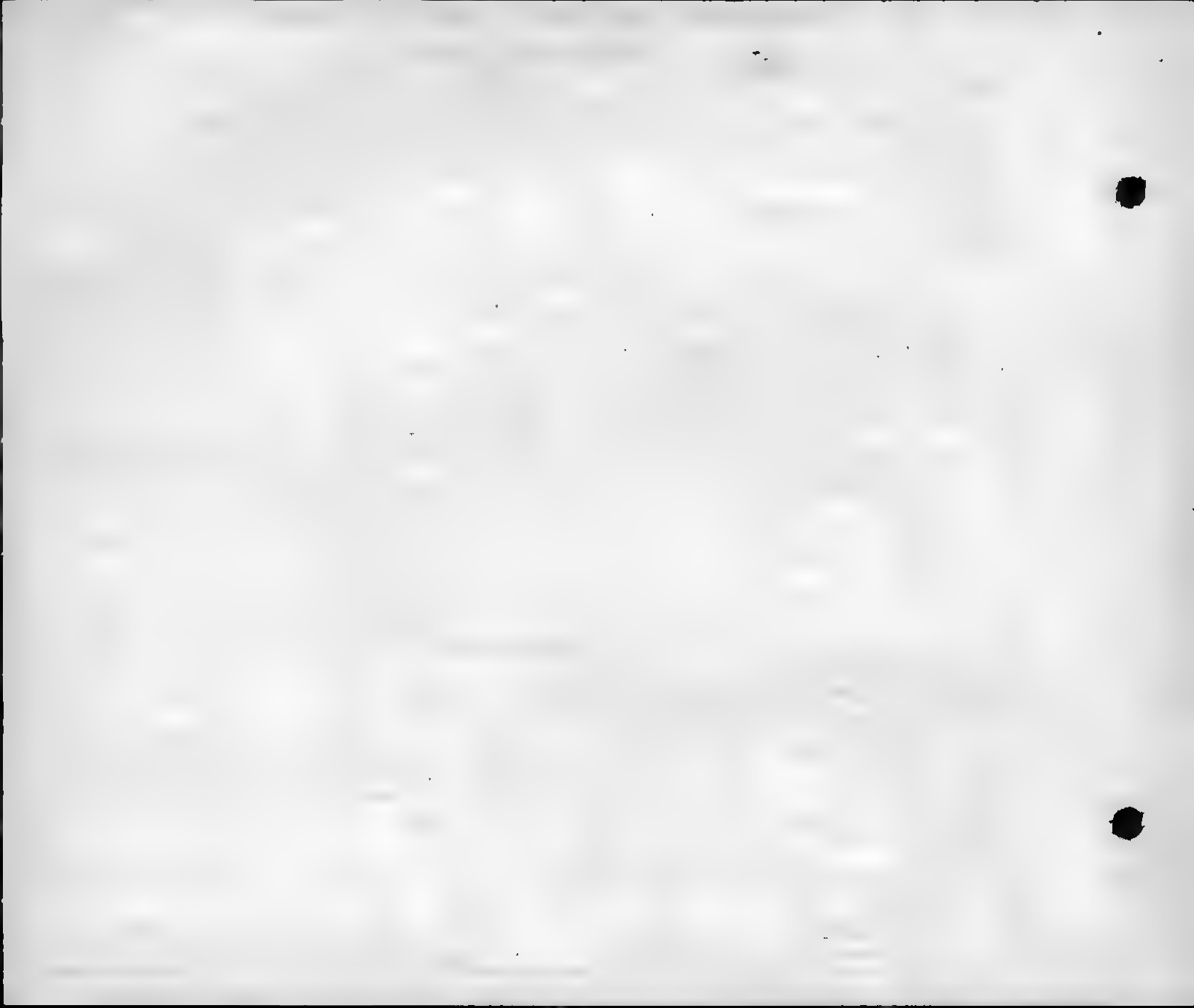
10432

## CERTIFICATE OF DEATH

10392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5208 Gretchen Street</b>		d. STREET ADDRESS <b>5208 Gretchen Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH VERONICA GILLESPIE</b>		4. DATE OF DEATH Month Day Year <b>Sept. 13, 1959 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1878</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Thomas Kline</b>		14. MOTHER'S MAIDEN NAME <b>? O'Toole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>282-26-1486</b>	
17. INFORMANT <b>Thomas J. Gillespie-Item# 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Disease - Coronary - Both Branches</b>			
DUE TO (b) <b>Adenocarcinoma of the Thymus</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 10, 1958</b> to <b>Sept 13, 1959</b> , that I last saw the deceased alive on <b>Sept 13, 1959</b> , and that death occurred at <b>11:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William F. Smith</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>7/4/59</b>	
PHYSICIAN'S NAME (Type) <b>W. H. T. H. M. D.</b>		<b>ROCKVILLE, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>9/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Calvert</b>		22d. LOCATION (City, town, or county) (State) <b>Cleveland, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler-1331 E. Montgomery Ave. Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 18 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>			





10433

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>30 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. STREET ADDRESS <u>5608 Randolph Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Gilliss</u>		4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2/1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. - Govt. office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Trazila, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Scott Gilliss</u>		14. MOTHER'S MAIDEN NAME <u>Reanna Harriet Ricketts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Viola L. Gilliss</u>		Address <u>5608 Randolph Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction - Anterior Septal</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 hours</u> <u>Unknown</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>Sept</u> Day <u>13</u> Year <u>1959</u> Hour <u>a. m.</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 13</u> , 19 <u>59</u> , to <u>Sept 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 13</u> , 19 <u>59</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Aaron H. Traum</u>		ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>		DATE SIGNED <u>9/14/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>SEP 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10394

Reg. Dist. No.

10434

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>7 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8914 1st Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mtgy</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8914 1st Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Adelaide C</u> First <u>Glisson</u> Middle Last <b>4. DATE OF DEATH</b> Month <u>Sept</u> Day <u>25</u> Year <u>1959</u>				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12-31-1883</u> <b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>John J. Glisson</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Adelaide Brown</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>no</u> <b>17. INFORMANT</b> <u>M. A. Glisson</u> Address <u>Stm 2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart disease</u> DUE TO (b) <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 day</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> 19 <u>  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> M.D. <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>9-25-59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>9/29/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Glenwood Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Washington, D.C.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur H. Hines</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>SEP 28 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur H. Hines</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL  
may be refiled  
TO FUNERAL L.  
page 3 should  
the registrar prior

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the hospital or attending physician.

death: Page 4

OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

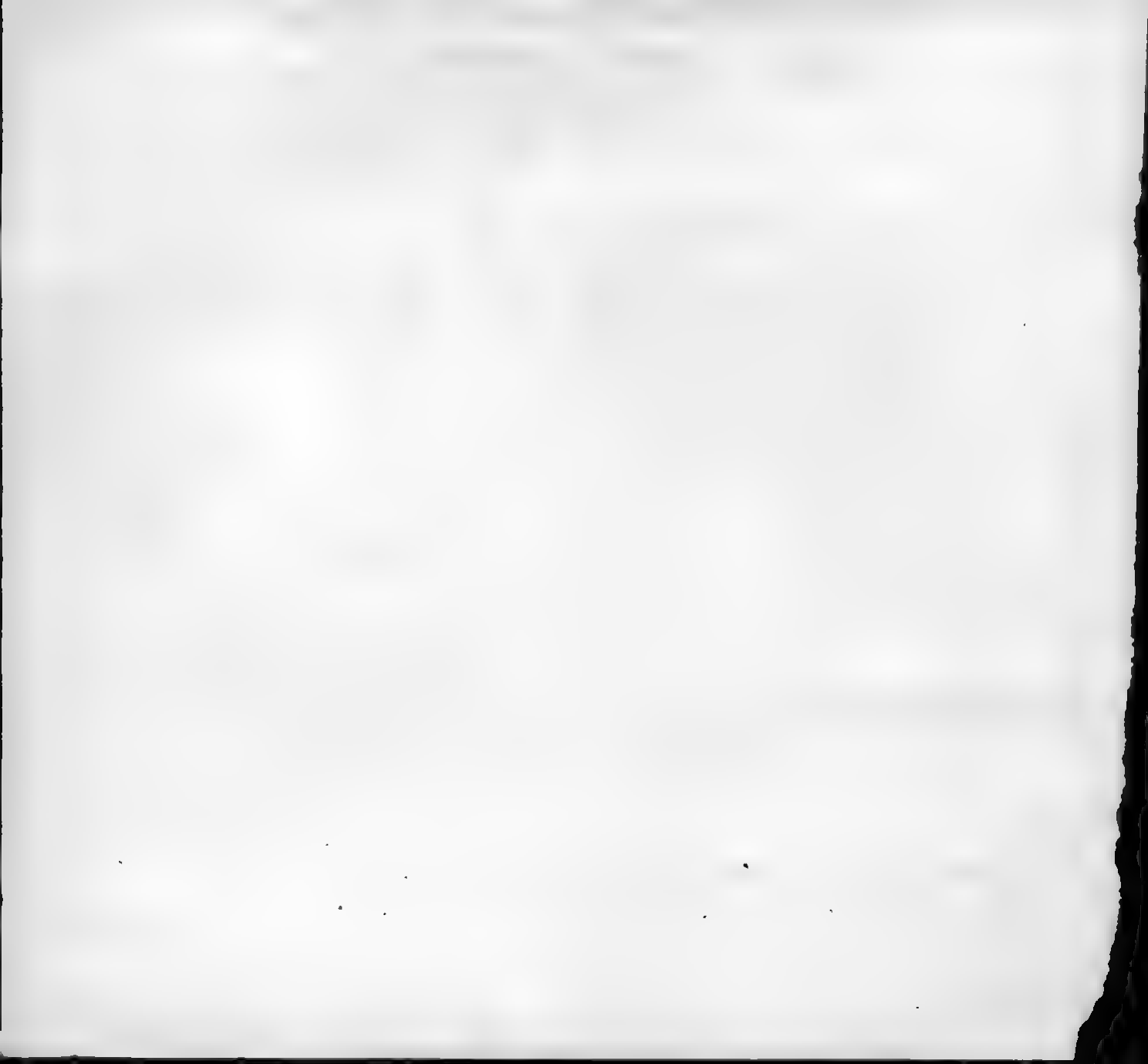
10354

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Scout Hosp.</u>				e. STREET ADDRESS <u>8313-14th Ave.</u>			
3. NAME OF <u>DECEASED</u> (Type or print) First <u>Samuel</u> Middle <u>Green</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-98</u>		9. AGE (In years last birthday) <u>60</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL - DEPT. STORE</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS GREENHOUSE</u>				14. MOTHER'S MAIDEN NAME <u>ANNA OGUSH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>172254682</u>		17. INFORMANT <u>Hospital records.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u>						<u>5 MIN.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ATHEROSCLEROSIS</u>						<u>2 YEARS.</u>	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HAY FEVER.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC. 19</u> , 19 <u>58</u> , to <u>SEPT 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>SEPT 8</u> , 19 <u>59</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James A. Roberts</u>				ADDRESS (Street, city or town, state) <u>8907 GEORGIA AVENUE</u>		DATE SIGNED <u>SEPT 9, 1959</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>				<u>SILVER SPRING, MARYLAND.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELESAVETGRAD CRM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY &amp; SONS - 3501-14th St NW</u>				24a. REC'D BY REGISTRAR <u>SEP 11 59</u>		24b. REGISTRAR'S SIGNATURE <u>Colbert L. Hanna</u>	

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10396

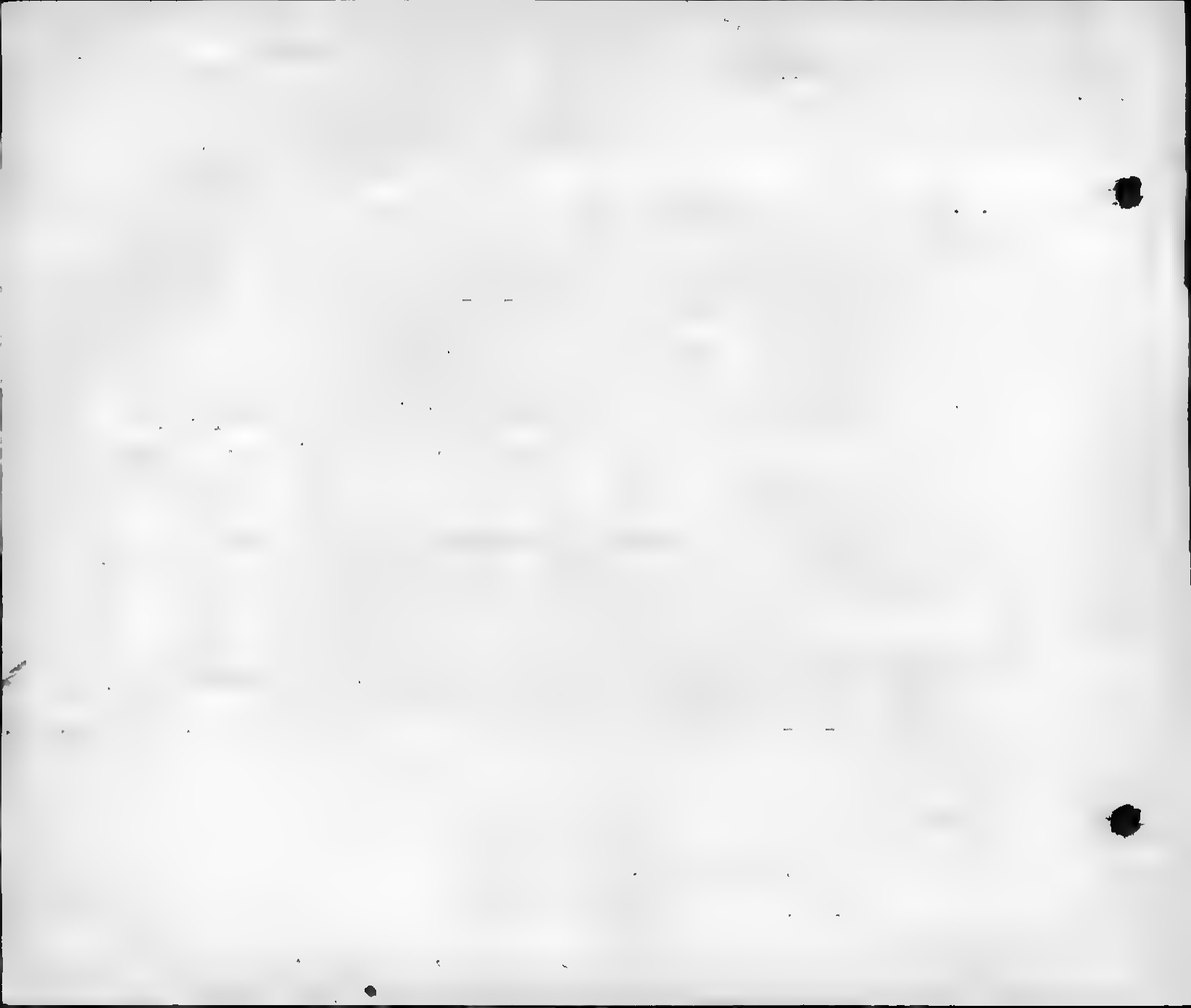
Reg. Dist. No. 215

10435

1. PLACE OF DEATH a COUNTY <b>MONTGOMERY</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c LENGTH OF STAY IN 1b <b>1 Hour 55 Min</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE <b>Virginia</b> b COUNTY <b>Stafford</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midway Island (Rural)</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital Bethesda Md</b>		e STREET ADDRESS <b>75 Henderson Drive</b>		f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Rex</b> Last <b>GRIFFIN</b>		4. DATE OF DEATH Month <b>September</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-16-59</b>	9. AGE (in years last birthday) yrs <b>3</b> Months <b>3</b> Days <b>3</b>	IF UNDER 24 HRS Hours <b>3</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>David Warren GRIFFIN</b>		14. MOTHER'S MAIDEN NAME <b>Betty Jean SMITH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT <b>75 Henderson Drive, Father, Midway Island, Virginia</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage and Laceration</b> DUE TO (c) <b>Bullet Wound</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 hours and 20 Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>22 Calibre pistol discharged while being loaded by father</b>			
20c. TIME OF INJURY Month, Day, Year <b>7:30 P.M. 9-19-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Midway Island, Stafford, Va.</b>	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		EXAMINER'S NAME (Type) <b>Frank J. BROSCHART,</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>9-20-59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Falmouth Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Falmouth Virginia</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>WHEELER &amp; Thompson Funeral Home, Fredricksburg, Va.</b>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Chas. J. Kline</b>	

SEP 23 59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397

10436

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>				c. LENGTH OF STAY IN 1b <u>1 MONTH</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARYLAND REST HOME</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Robert PAUL Grove</u>				4. DATE OF DEATH Month <u>9</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-1902</u>	
9. AGE (In years last birthday) <u>57</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u> Hours <u></u> Min <u></u>		11. BIRTHPLACE (State or foreign country) <u>Hugh Hesse PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT MGR</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>George W. Grove</u>				14. MOTHER'S MAIDEN NAME <u>Nettie B. Whoolery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. 17. INFORMANT <u>Theresa Grove</u> Address <u>Germantown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept. 5, 1959</u> , to <u>Sept. 20, 1959</u> , that I last saw the deceased alive on <u>Sept. 19, 1959</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James P. Kerr</u>				ADDRESS (Street, city or town, state) <u>Washington, Md.</u>			
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>				DATE SIGNED <u>9/20/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Faith Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u> <u>PE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hayden B. Deane</u>				ADDRESS <u>New Market</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clara A. Hays</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10437

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>FAUQUER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - BEALETON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BEALETON.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5142 NORTHINGTON DR. WESTGATE</b>				d. STREET ADDRESS <b>—</b>			
3. NAME OF DECEASED (Type or print) <b>EDWARD FLETCHER</b> First Middle Last				4. DATE OF DEATH <b>Sept. 24</b> Month Day Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/26/1891</b>	9. AGE (In years last birthday) <b>67</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES E. HALL</b>				14. MOTHER'S MAIDEN NAME <b>SUSIE BRAUND.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>577-34-9786</b>		17. INFORMANT Address <b>EDWARD HALL JR 5142 NORTHINGTON DR.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> <b>years</b> <b>years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 21, 1959</b> , to <b>Sept 24, 1959</b> , that I last saw the deceased alive on <b>Sept 24, 1959</b> , and that death occurred at <b>11:55 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. P. RYLAND</b>				ADDRESS (Street, city or town, state) <b>4400-49 ST. NW. Washington 16 DC.</b>			
PHYSICIAN'S NAME (Type) <b>C. P. RYLAND.</b>				DATE SIGNED <b>9-25-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>SEPT. 27 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BEALETON</b>		22d. LOCATION (City, town or county) (State) <b>BEALETON VA.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Sadell Moser</b> ADDRESS <b>Warrenton, Va</b>				24a. REC'D BY REGISTRAR <b>DATE SEP 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Chas &amp; Hines</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

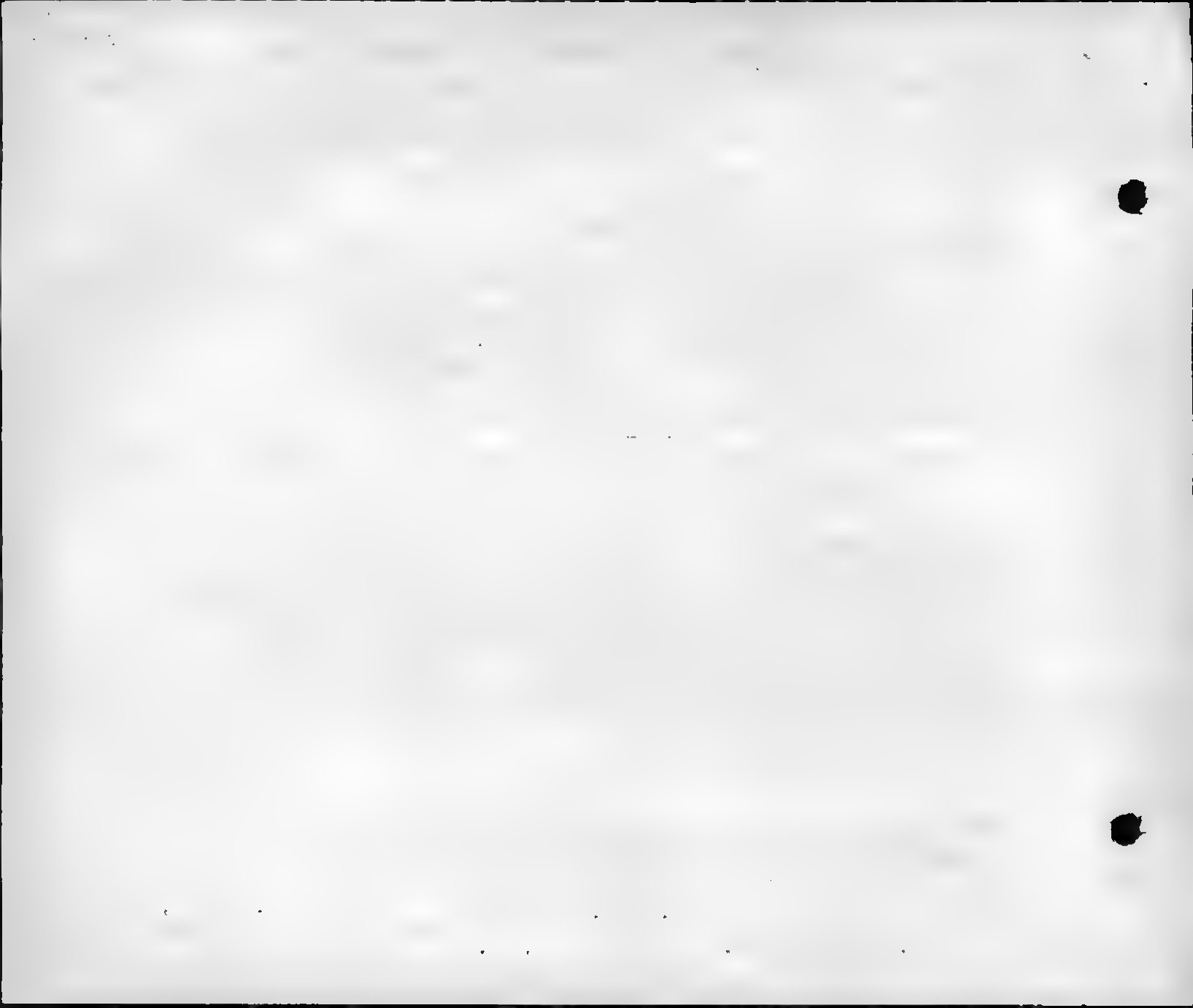
10399

Reg. Dist. No.

10355

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sen. &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1026 Quebec Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Peter</u> Middle <u>E.</u> Last <u>Hamstead</u>				<b>4. DATE OF DEATH</b> Month <u>9</u> - Day <u>14</u> Year <u>1959</u>											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>Whte</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2-10-1892</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Montgomery High School</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Ill., West Va.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>SEYMOUR</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Matilda Fihe</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>234-28-7068</u>				<b>17. INFORMANT</b> Address <u>Morton H. Hamstead, + 702-616-1414</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4x0.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>  </u> DUE TO (c) <u>  </u>												INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>															
<b>20a. EXTERNAL CAUSE</b> WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>9/17/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>GEO. WASH. CEMETERY</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WERNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>						<b>ADDRESS</b> <u>SILVER SPRING, MD.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE SEP 18 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



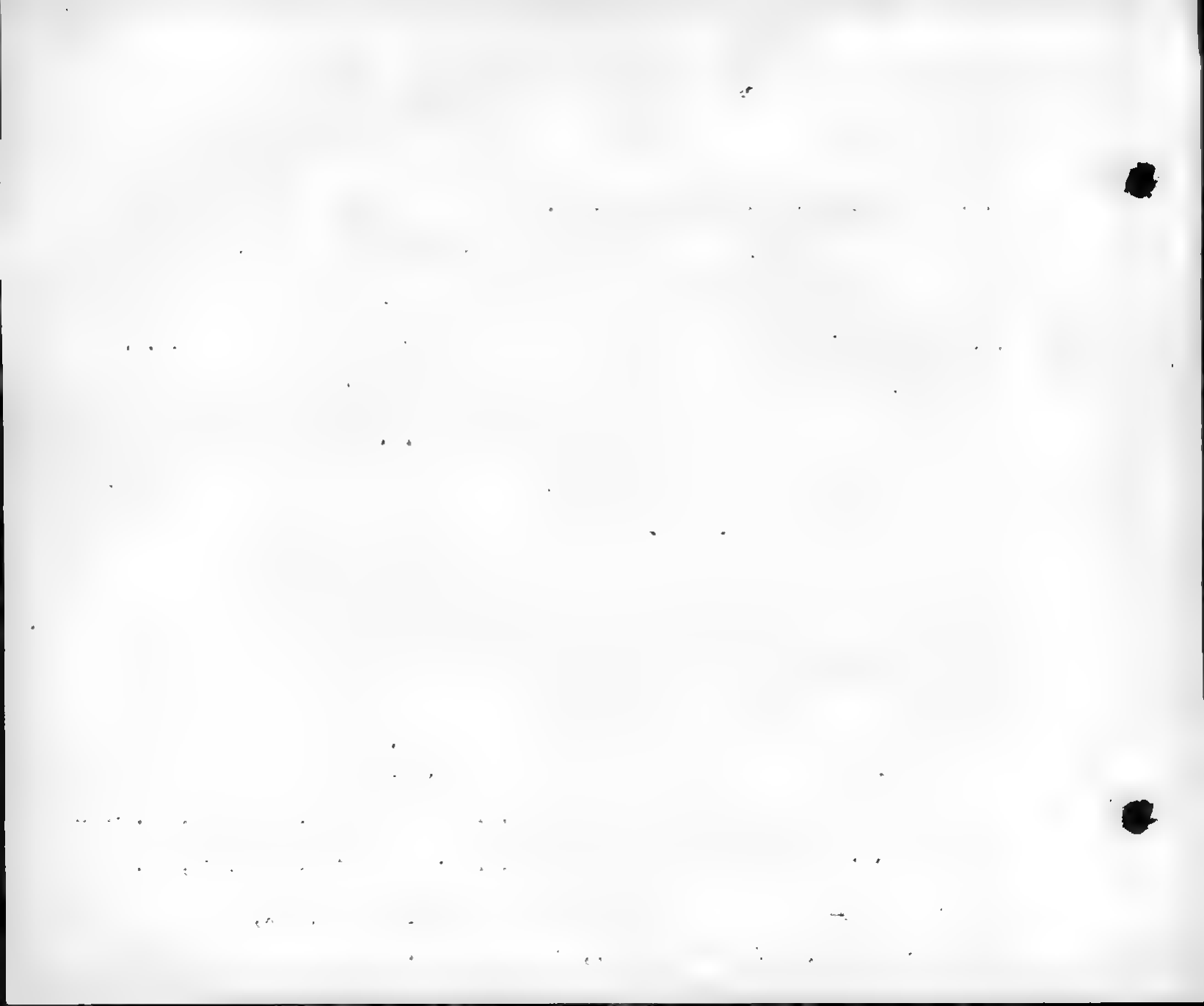
## 10438 - CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on. Res dence before admission) STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marrifield</b>	
c. LENGTH OF STAY IN 1b <b>9 1/2 hours</b>		d. STREET ADDRESS <b>Box 285</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Nava l Hospita l, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edwin (none) HANNA</b>		4. DATE OF DEATH Month Day Year <b>September 5 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 3, 1896</b>
9. AGE (In years last birthday) yrs. <b>63</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. NAVY (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur HANNA</b>		14. MOTHER'S MAIDEN NAME <b>Margaret DONOVAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>YES</b>		16. SOCIAL SECURITY NO <b>230 42 1072 (Wife) Selma E. HANNA</b>	
17. INFORMANT <b>(Same as #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Failure</b> <b>2200</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 day s</b> <b>3 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 September, 1959</b> , to <b>5 September, 1959</b> , that I last saw the deceased alive on <b>5 September, 1959</b> and that death occurred at <b>8:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 9-5-59</b>			
ACTUAL SIGNATURE <b>Joseph E. Stitchek</b>		PHYSICIAN'S NAME <b>J.E. STITCHER LCDR MC USN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-9-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington</b>		22d. LOCATION (City, town, or county) (State) <b>Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>IVES Funeral Home, 2827 Wilson Blvd., Arlington, Va.</b>		24a. REC'D BY REGISTRAR <b>SEP 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





10439

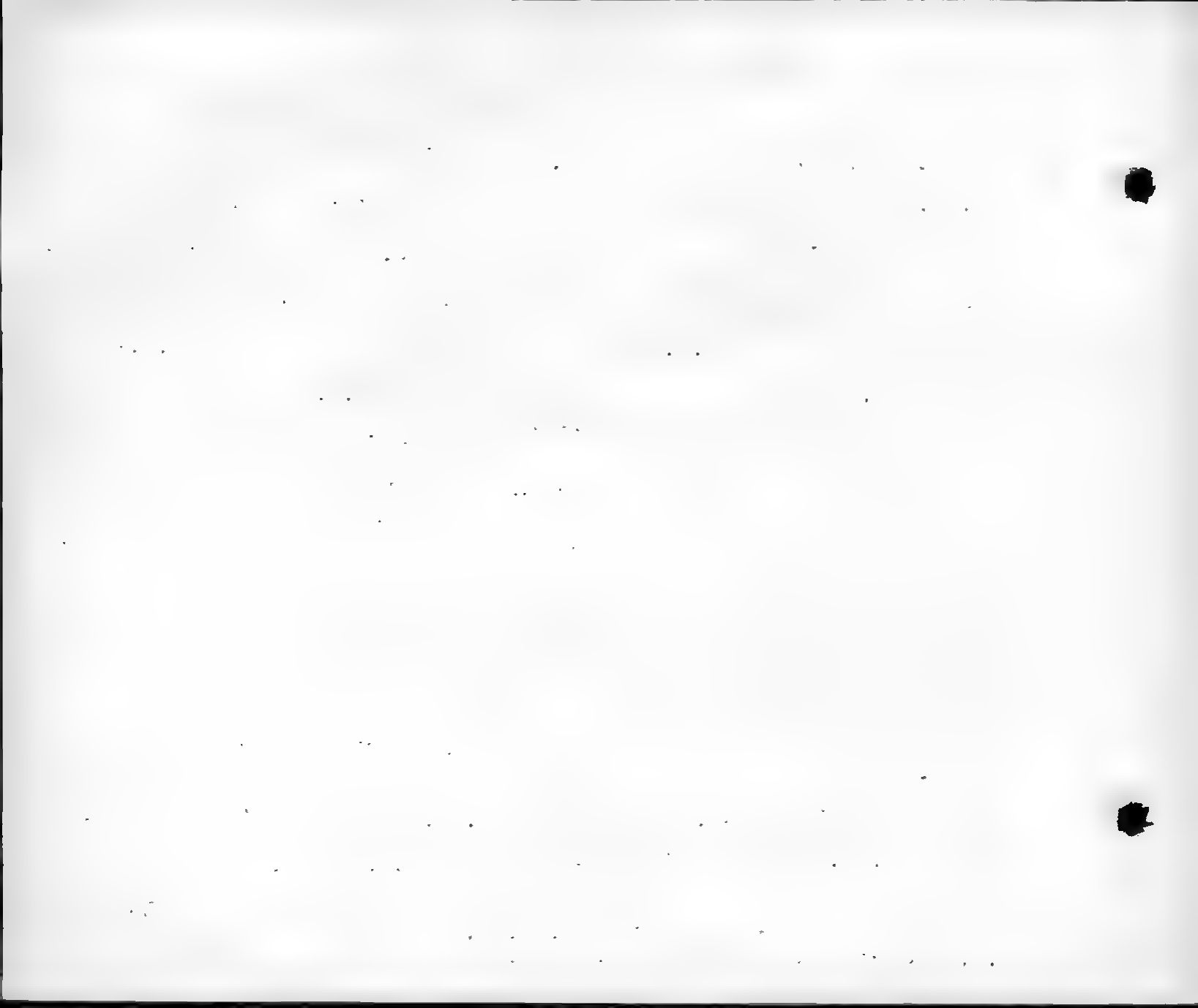
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>1yr. 2mos.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>9311 West Parkhill Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Burton</b> Middle <b>"S"</b> Last <b>HANSON, JR.</b>				4. DATE OF DEATH Month <b>September</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-1-07</b>	
9. AGE (In years last birthday) <b>52</b> yrs		IF UNDER 1 YEAR Months <b>52</b>		IF UNDER 24 HRS Days <b>52</b>		Hours <b>52</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Burton S. HANSON</b>				14. MOTHER'S MAIDEN NAME <b>Ruby May BARNES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>6/5/30 to 5/21/59 212-38-7055</b>			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>163X Carcinoma of lung, bilateral &amp; extensive metastases</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				INTERVAL BETWEEN ONSET AND DEATH <b>8 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19 19 58</b> to <b>Sept 2 19 59</b> that I last saw the deceased alive on <b>Sept. 2 19 59</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital 9-3-59</b>							
ACTUAL SIGNATURE <b>B. C. Johnson</b>				M.D. <b>U. S. Naval Hospital</b>			
PHYSICIAN'S NAME (Type) <b>B. C. JOHNSON, LCDR, MC, USN</b>				<b>Bethesda, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>				24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10440

## CERTIFICATE OF DEATH

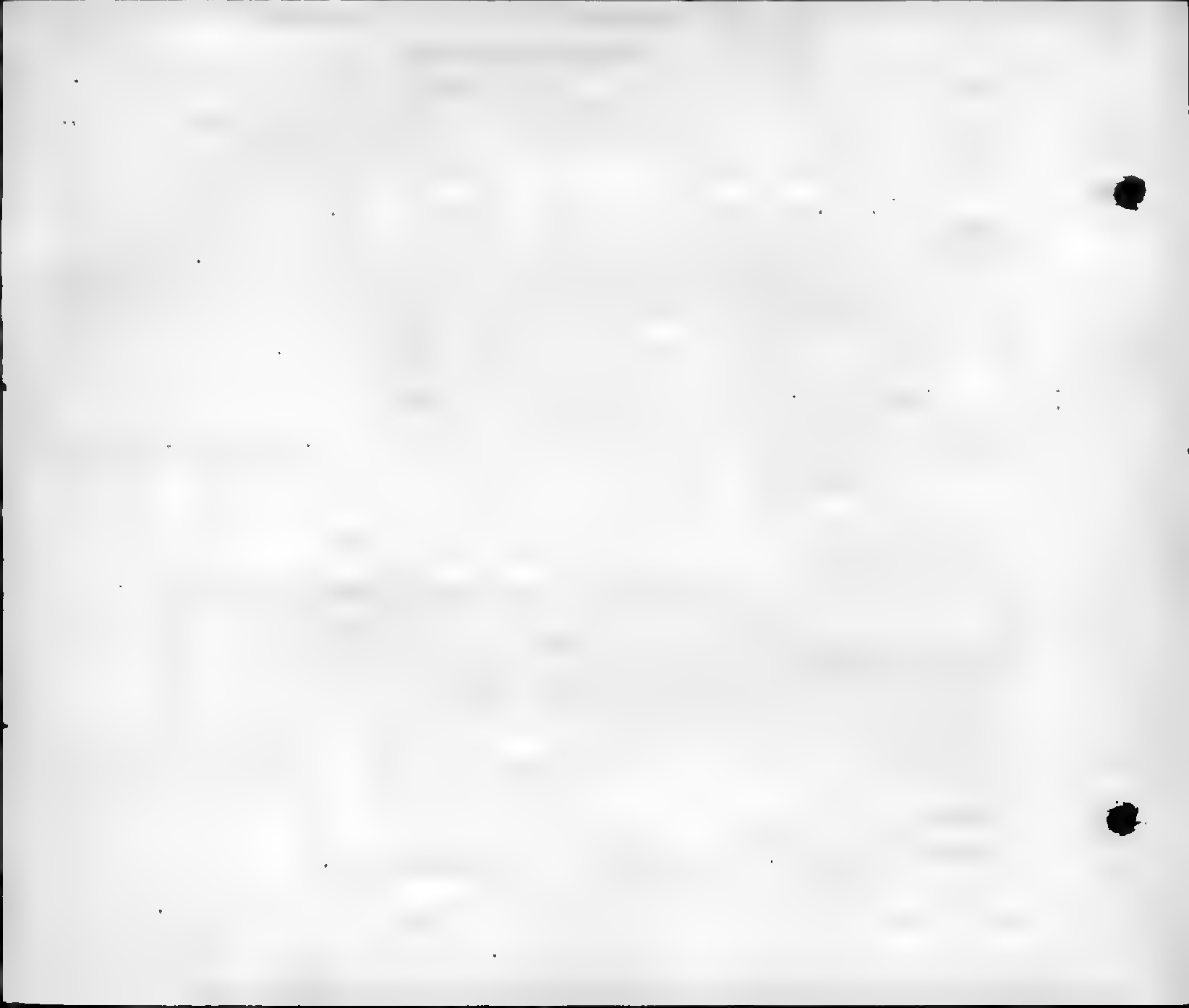
10402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Clagettsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Clagettsville</b>			
c. LENGTH OF STAY in 1b <b>5 yrs</b>				d. STREET ADDRESS <b>RFD #3, Mt. Airy</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD #3, Mt. Airy</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret Mae Harrell</b>				4. DATE OF DEATH Month Day Year <b>Sept. 19 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1885</b>	9. AGE (In years last birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harrison S. Harrell</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Nebringer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>--</b>		17. INFORMANT Address <b>Mrs Rena Brown, Mt. Airy, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary atherosclerotic cardiovascular disease</b> DUE TO (b) <b>Neurogenic degeneration of legs &amp; feet</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b> <b>15 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 10, 1955</b> , to <b>Sept. 19, 1959</b> , that I last saw the deceased alive on <b>Sept. 16, 1959</b> , and that death occurred at <b>7:20 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James P. Kerr</b>				ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>			
PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>				DATE SIGNED <b>7/19/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Boonesboro Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Boonesboro, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William L. Mohan</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 22 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>William L. Mohan</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10441

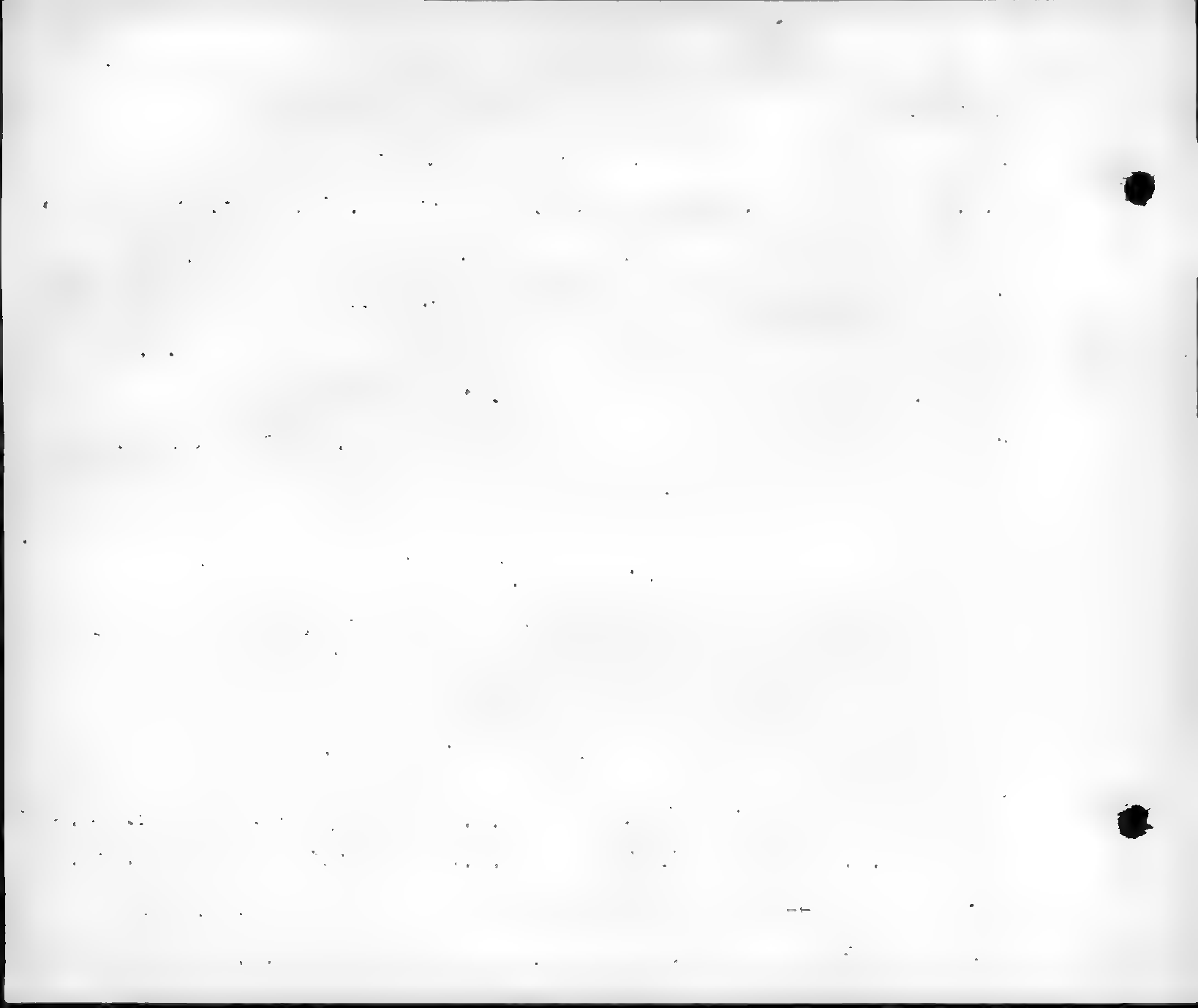
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>1 Mo. 4 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY <b>47x-5</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>4256 4th St. SE, Apt. #3</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Earl Ray HARRIS</b>		4. DATE OF DEATH Month Day Year <b>September 5 1959</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	
8. DATE OF BIRTH <b>April 23, 1959</b>		9. AGE (In years last birthday) <b>4 yrs. 13</b>		IF UNDER 1 YEAR Months Days Hours Min <b>4 13</b>		IF UNDER 24 HRS Hours Min <b>13</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Earl G. HARRIS</b>		14. MOTHER'S MAIDEN NAME <b>Janice Jane FELTS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>INFORMANT</b>		Address <b>(Father) Earl G. HARRIS Same as #2</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>755X</b> DUE TO <b>Virus pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) <b>following surgery for harelip with tracheotomy</b> DUE TO (c) <b>3 wks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Febrile convulsions with spasticity and coma</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter notes of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, store, office bldg., etc.) <b>U.S. Naval Hospital, Bethesda, Md.</b>	
20f. (City or town) <b>Bethesda, Md.</b>		(County) <b>Montgomery</b>		(State) <b>Md.</b>		21. I certify that I attended the deceased from <b>1 August, 1959</b> to <b>5 Sept., 1959</b> and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above.		DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 9-7-59</b>	
ACTUAL SIGNATURE <b>G.B. Avery</b>		M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>		PHYSICIAN'S NAME (Type) <b>G.B. AVERY, LT MC USN</b>		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>		(State) <b>Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chambers Funeral Home</b>		24a. REC'D BY REGISTRAR <b>517 11th St. SE, Washington, D.C. 20003</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Jones</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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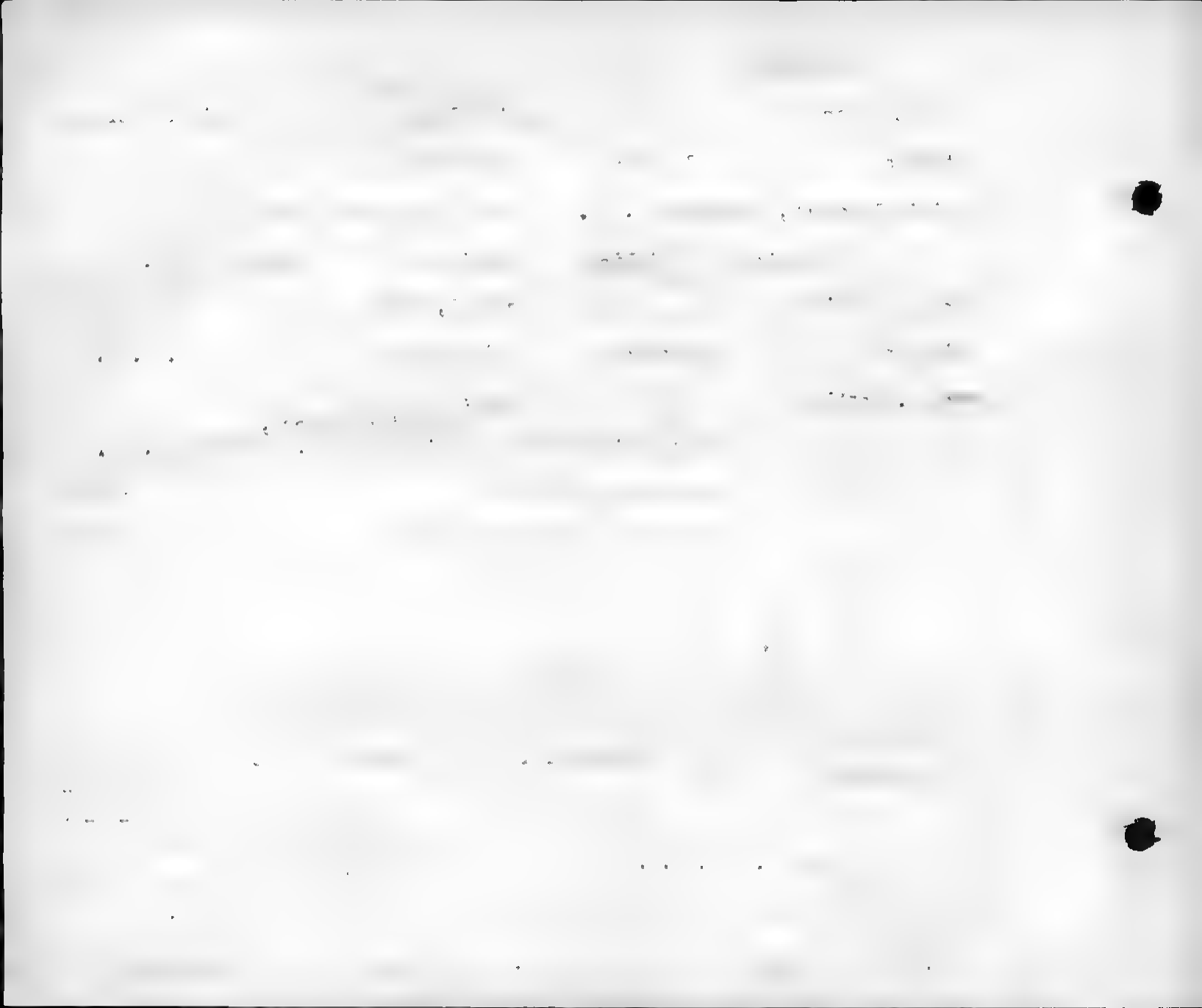


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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10404
Item 18 Film 249 10-15-59 ams										10442
CERTIFICATE OF DEATH										Reg. Dist. No.
1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Bethesda</b>					c. LENGTH OF STAY IN 1b <b>15 days</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>					d. STREET ADDRESS <b>5008 Lexington Avenue</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louise Williams Hastings</b>					4. DATE OF DEATH Month Day Year <b>September 25, 1959</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 1, 1906</b>		9. AGE (In years lost birthday) <b>52</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>Abraham C. Hastings</b>					14. MOTHER'S MAIDEN NAME <b>Lenna Giles</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO <b>Unascertainable</b>					
17. INFORMANT <b>The Medical Record,</b> Address <b>The Clinical Center, Bethesda 14, Md.</b>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>										
420.0 DUE TO <b>Arteriosclerotic heart disease</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b>										
(c) <b>Arteriosclerotic heart disease</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>										
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>										
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										
20f. (City or town) (County) (State)										
21. I certify that I attended the deceased from <b>September 10 1959</b> to <b>September 25 1959</b> , that I last saw the deceased alive on <b>September 25</b> , 19 <b>59</b> , and that death occurred at <b>1:00</b> P.M., from the causes and on the date stated above.										
ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>9-25-59</b>										
SIGNATURE <b>William S. Sly</b> M.D. <b>The Clinical Center</b>										
PHYSICIAN'S NAME (Type) <b>William S. Sly, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										
22b. DATE THEREOF <b>9/28/59</b>										
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>										
22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>										
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>										
24a. REC'D BY REGISTRAR <b>SEP 29 '59</b>										
24b. REGISTRAR'S SIGNATURE <b>Arthur H. Hanna</b>										

MEDICAL CERTIFICATION





10443

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>15</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Walker Hayer</u>		4. DATE OF DEATH Month Day Year <u>9 29 1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 24, 1895</u>
9. AGE (In years last birthday) <u>104</u> yrs.		10. AGE (In years last birthday) <u>104</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Terreland Walker</u>		14. MOTHER'S MAIDEN NAME <u>Elise Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency &amp; myocarditis</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 wk</u> (c) <u>6 months</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis of left popliteal artery</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 Dec 1957</u> to <u>29 Sept 1959</u> that I last saw the deceased alive on <u>28 Sept 1959</u> , and that death occurred at <u>8:45 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert Martyn Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave Bethesda Md.</u> DATE SIGNED <u>29 Sept 59</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR.</u>			
22a. DATE OF CREMATION <u>10/1/59</u>	22b. DATE THEREOF <u>10/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory Prince Georges County, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.-2901 14th St., N.W.</u>		24a. REC'D BY REGISTRAR <u>OCT 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>			

10443

VS A15 (4)  
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10444

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>3 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2124 Briggs-Chaney Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Ellen</b> Last <b>Hayghe</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/14/84</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HENRY ARNOLD</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE MISSOURI MELSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>Mr. William H. Hayghe, 9909 Woodburn Rd.</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Artery Disease</b> <b>420.0</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/3/1959</b> to <b>9/23/1959</b> , that I last saw the deceased alive on <b>9/11/1959</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8001 Campville Rd., Silver Spring, Md.</b> DATE SIGNED <b>9/23/59</b>			
ACTUAL SIGNATURE <b>Russell B. Arnold M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Russell B. Arnold M.D. Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CONGRESSIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Liska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>SEP 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Krueger</b>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

10407

Reg. Dist. No.

10445

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission, a. STATE <u>Virginia</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Ann</u> Last <u>Hedges</u>		4. DATE OF DEATH Month <u>9</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/34</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>	11. BIRTHPLACE (State or foreign country) <u>Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Paul Ervin</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>479-403053</u>		17. INFORMANT <u>Robert A. Hedges, 2024 Columbia Pkwy.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast with metastases</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>16 mo.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Feb. 1955</u> , 19 <u>55</u> , to <u>Sept 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 17</u> , 19 <u>59</u> , and that death occurred at <u>10:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Murphy</u>		ADDRESS (Street, city or town, state) <u>1504 Eye St. NW Washington D.C.</u> DATE SIGNED <u>SEP 23 '59</u>	
PHYSICIAN'S NAME (Type) <u>John C. Murphy</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-20-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLENDALE MASONIC</u>	22d. LOCATION (City, town, or county) (State) <u>DES MOINES, IOWA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Jewellers Sons. Washington D.C.</u>		24. REC'D BY REGISTRAR <u>SEP 23 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

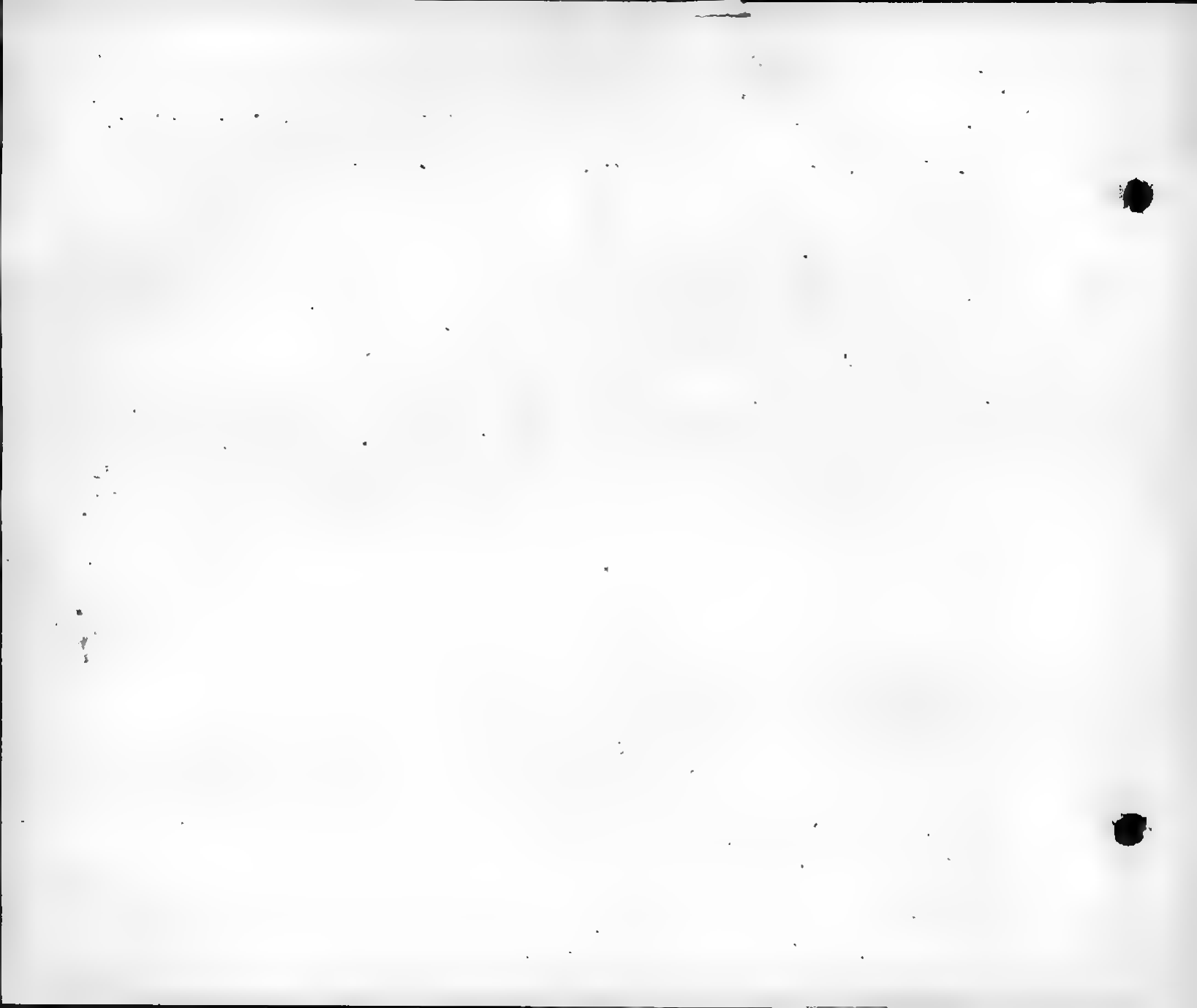
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10356

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG248 9-22-59 et

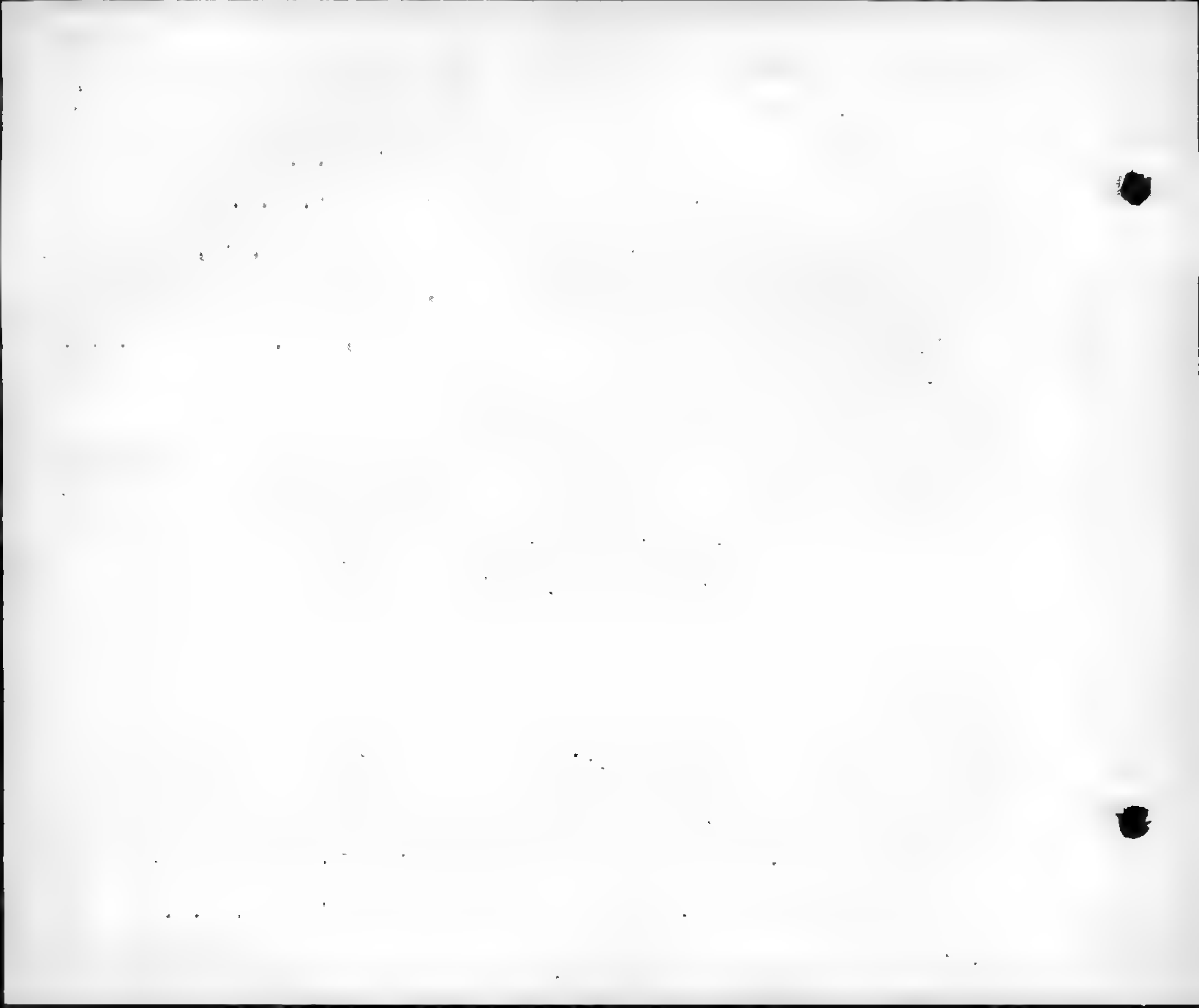
CERTIFICATE OF DEATH

Reg. Dist. No.

10408

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>WASHINGTON, D.C.</b> b. COUNTY <b>47X-5</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lakoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium</b>		d. STREET ADDRESS <b>7216 - 14th St. N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>HENRY</b> First <b>A</b> Middle <b>HEINE</b> Last		4. DATE OF DEATH <b>Sept. 15,</b> 19 <b>59</b> Month <b>15</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1885</b>
9. AGE (In years last birthday) <b>76 7/4</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Heine</b>		14. MOTHER'S MAIDEN NAME <b>Marie Heitmuller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>18. x</b> <b>Uremia</b> DUE TO (b) <b>Bilateral ureteral obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Carcinoma of left ureter</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 week</b> <b>22 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>18 June, 1959</b> to <b>15 Sept. 1959</b> , that I last saw the deceased alive on <b>15 Sept. 1959</b> , and that death occurred at <b>8:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Seruch T. Kimble</b>		ADDRESS (Street, city or town, state) <b>729 Pershing Drive, Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Seruch T. Kimble</b>		DATE SIGNED <b>SEP 15 '59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>9/18/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. H. Hiner</b>		ADDRESS <b>2901-14th St. N.W. Washington 9, D.C.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





10446

CERTIFICATE OF DEATH

10499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>10237 Seven Locks Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Henderson</u>		4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/28/59</u>
9. AGE (In years last birthday) yrs <u>15</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOT GIVEN</u>		14. MOTHER'S MAIDEN NAME <u>CAROL HENRIETTA HENDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MOTHER</u>		Address <u>707 H.R.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atelectasis</u> 762.5 DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u> <u>16 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>9-28</u> , 19 <u>59</u> , to <u>9-29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-29</u> , 19 <u>59</u> , and that death occurred at <u>2:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis J. Troendle</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd., Rockville Md</u>	
PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>		DATE SIGNED <u>9-29-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9-29-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital 8600 Old Georgetown Road, Bethesda Md</u>		24a. REC'D BY REGISTRAR <u>Oct 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>			

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10447

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Springfield</u>		c. LENGTH OF STAY IN 1b. <u>14 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5705 Ridgelyfield</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>Stanton</u> Last <u>Henry</u>				4. DATE OF DEATH Month <u>Sept</u> Day Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 March 1891</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman &amp; Manager Tire Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tire Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edwin Stanton Henry Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Beese</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>Yes 1 WW I</u>		16. SOCIAL SECURITY NO. <u>162-01-6278</u>		17. INFORMANT <u>Wife - Isabel B. Henry</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate with Metastasis</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic &amp; Valvular Heart Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Sept. 1959</u> to <u>1 Sept. 1959</u> , that I last saw the deceased alive on <u>1 Sept. 1959</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry A. Horstman</u> M.D. <u>1835 Eye St. W.W. Wash. D.C.</u>				DATE SIGNED <u>1 Sept. 59</u>			
PHYSICIAN'S NAME (Type) <u>Harry A. Horstman, Jr.</u>				ADDRESS (Street, city or town, state) <u>1835 EYE ST., N.W. WASH., D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hamblet's Sons</u> ADDRESS <u>1756 Pa. Ave., N.W. DC</u>				24a. REC'D BY REGISTRAR <u>SEP 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 10448 CERTIFICATE OF DEATH

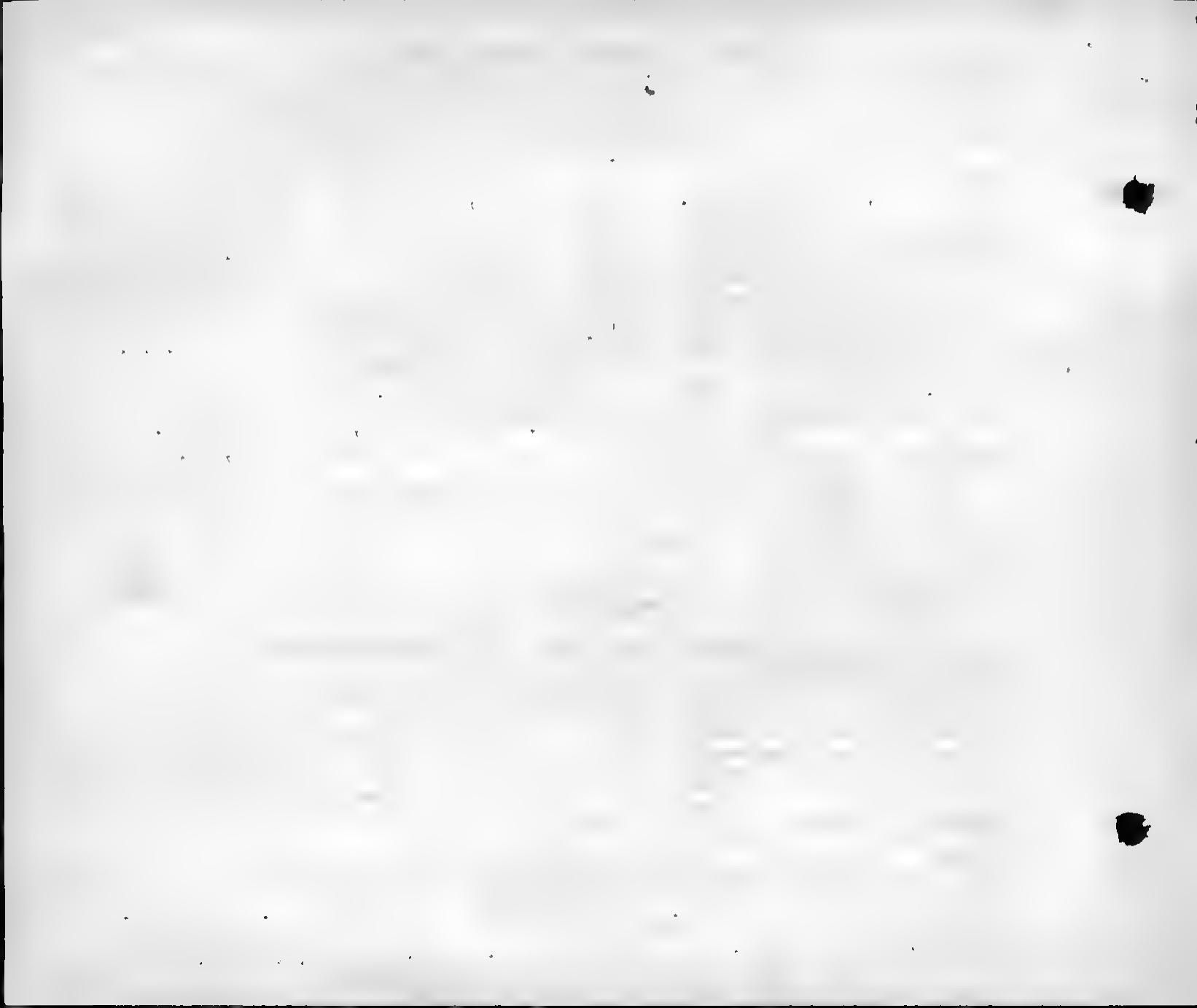
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,005 GREELEY AVE.</b>		d. STREET ADDRESS <b>10,005 GREELEY AVENUE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SUSAN</b> Middle <b>CLAIBORNE</b> Last <b>HOLLAND</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/22/80</b>
9. AGE (In years last birthday) yrs <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk (retired) Bureau of Engraving</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN L. SMITHER</b>		14. MOTHER'S MAIDEN NAME <b>LEONORA J. GARY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Leonora Hogan, 7012 Emerson St. Landover Hills, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>5 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 15</b> , 19 <b>40</b> , to <b>Sept 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 26</b> , 19 <b>59</b> , and that death occurred at <b>4:52 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur H. Lewis</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>1714 R. S. Ave NW Washington 6 DC</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR H. LEWIS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WAGNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 29 '59</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



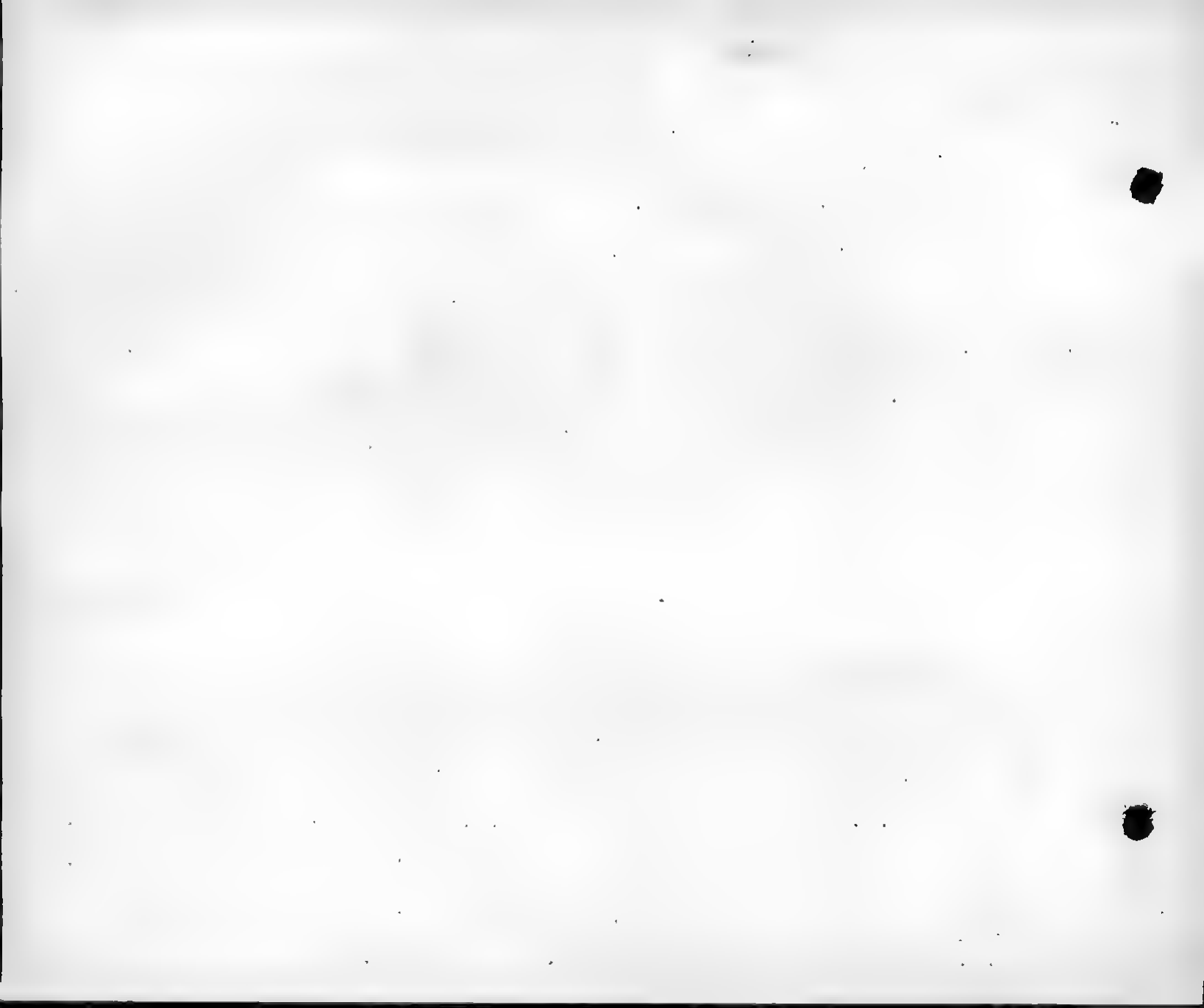
10449

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>105 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>District</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>U.S. Hospital, Bethesda, Md.</b>		e. STREET ADDRESS <b>5809 Sonoma Road</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter Coler HOLT</b>		4. DATE OF DEATH Month Day Year <b>September 28 1959</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10-14-99</b>		9. AGE (in years last birthday) <b>59 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Walter H. HOLT</b>		14. MOTHER'S MAIDEN NAME <b>Virginia FRARY</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>WW II</b>		17. INFORMANT <b>(wife) Julia D. HOLT Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Lympho Sarcoma</b> <b>200.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7.6 yrs</b>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. City or town (County) (State)		21. I certify that I attended the deceased from <b>15 June</b> , 19 <b>59</b> to <b>28 Sept</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>28 September</b> , 19 <b>59</b> , and that death occurred at <b>0:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md.</b> <b>9-28-59</b>		ACTUAL SIGNATURE <b>B.M. WEBB LT MC USN</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>		PHYSICIAN'S NAME (Type) <b>U.S. Naval Hospital, Bethesda Md.</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-1-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		24a. REC'D BY REGISTRAR <b>Oct 1 '59</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		24c. ADDRESS <b>7557 Wisconsin Ave. Bethesda Md.</b>		24d. DATE <b>Oct 1 '59</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10450

CERTIFICATE OF DEATH

10413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRINGS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRINGS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8674 PINEY BRANCH ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BARBARA</u> Middle <u>HORSEY</u> Last <u>HORSEY</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 4 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM J. NICHOLS</u>		14. MOTHER'S MAIDEN NAME <u>RHODA MARINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>RUENUS N. HORSEY</u>		Address <u>8674 PINEY BR. RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> (c) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 2</u> , 19 <u>59</u> , to <u>Sept 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 3</u> , 19 <u>59</u> , and that death occurred at <u>4:50</u> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>5601-4 21 NW</u> DATE SIGNED <u>Washington DC</u>			
ACTUAL SIGNATURE <u>F. X. Courtney</u> M.D.		PHYSICIAN'S NAME (Type) <u>Washington DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		24a. REC'D BY REGISTRAR <u>SEP 9 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10414

10451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1706 Dublin Drive</b>				d. STREET ADDRESS <b>1706 Dublin Drive</b>			
3. NAME OF DECEASED (Type or print) <b>Gertrude E Howell</b> First Middle Last				4. DATE OF DEATH Month <b>9</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 2, 1876</b>	
9. AGE (In years last birthday) <b>83</b>		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>- -</b>		17. INFORMANT <b>Carlton Howell 1706 Dublin Drive</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO <b>Diabetes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetic ulcer of foot</b> (c) <b>Diabetic ulcer of foot</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>20 yrs</b> <b>2 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1943</b> to <b>9/15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 15</b> , 19 <b>59</b> , and that death occurred at <b>1 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1831 Varnum St. N.E.</b> DATE SIGNED ACTUAL SIGNATURE <b>Leland S. Madden</b> M.D. PHYSICIAN'S NAME (Type) <b>Leland S. Madden Washington D.C.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deaf Funeral Home</b>				ADDRESS <b>4812 Ga. Ave. N. W.</b>		24a. REC'D BY REGISTRAR <b>SEP 18 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G249 2/25/59

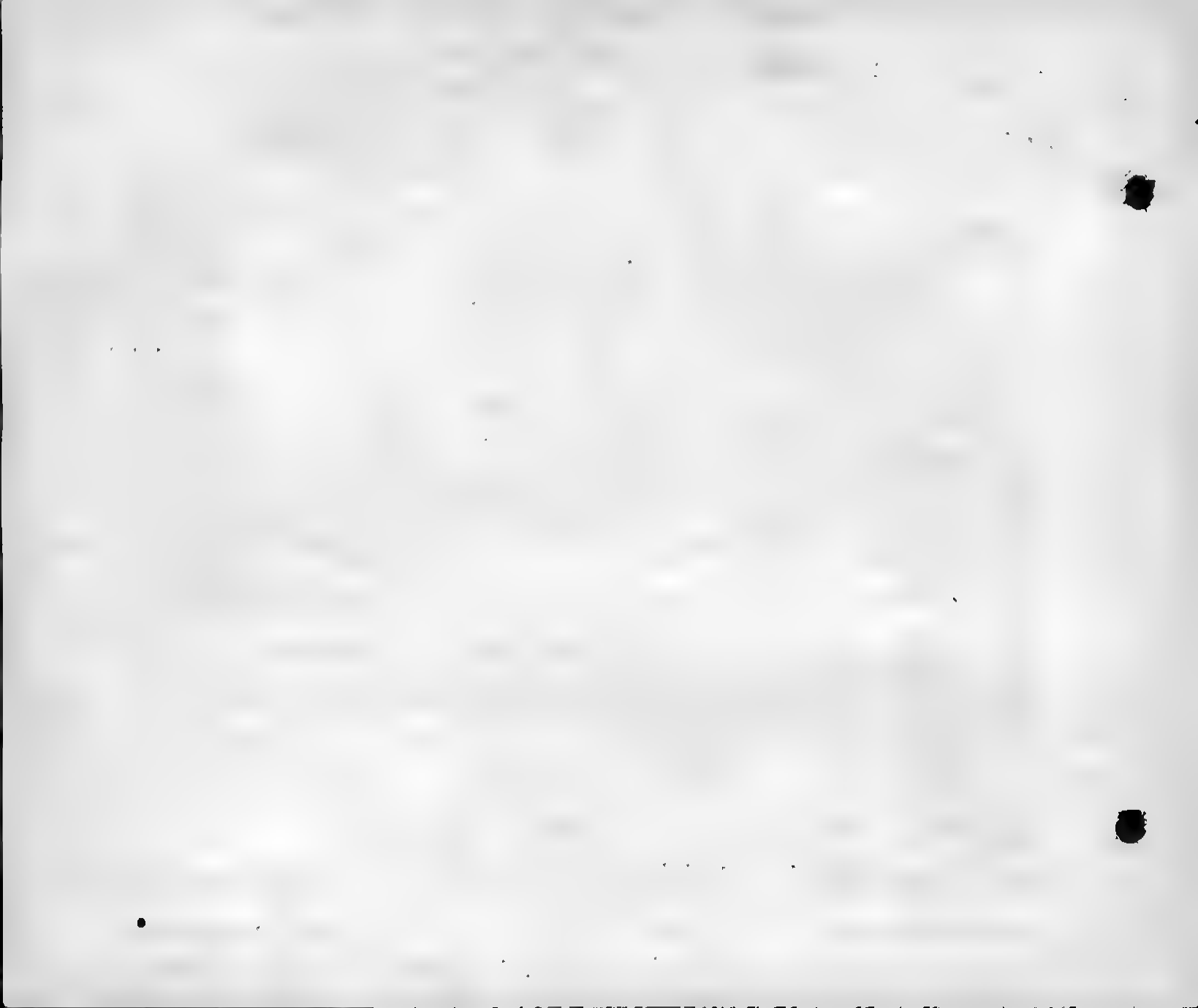
## CERTIFICATE OF DEATH

Reg. Dist. No.

10415

10452

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germanstown</b>		c. LENGTH OF STAY IN TB <b>6 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Marylander Home of Rest</b>		d. STREET ADDRESS <b>Ann Arbor, Mich.</b>	
3. NAME OF DECEASED (Type or print) First <b>Kate</b> Middle <b>C.</b> Last <b>Hubbard</b>		4. DATE OF DEATH Month <b>9</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/13/71</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>5</b> Hours <b>15</b> Min <b>00</b>	IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alancer Slater</b>		14. MOTHER'S MAIDEN NAME <b>Anne Chapman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Records-The Marylander Home of Rest</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) <b>Neurogenic degeneration of feet &amp; legs</b> DUE TO (c) <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1936</b> to <b>Sept 19, 1959</b> , that I last saw the deceased alive on <b>Sept 15, 1959</b> , and that death occurred at <b>---</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James P. Kerr</b>		DATE SIGNED <b>9/19/59</b>	
PHYSICIAN'S NAME (Type) <b>James P. Kerr, M.D.</b>		ADDRESS (Street, city or town, state) <b>Danvers, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/2/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chestnut Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Ashtabula, Ohio</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Farmer</b>		24a. REC'D BY REGISTRAR <b>SEP 21 '59</b>	
ADDRESS <b>315 E. Diamond Ave., Gaithersburg, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>	



## 0453

# CERTIFICATE OF DEATH

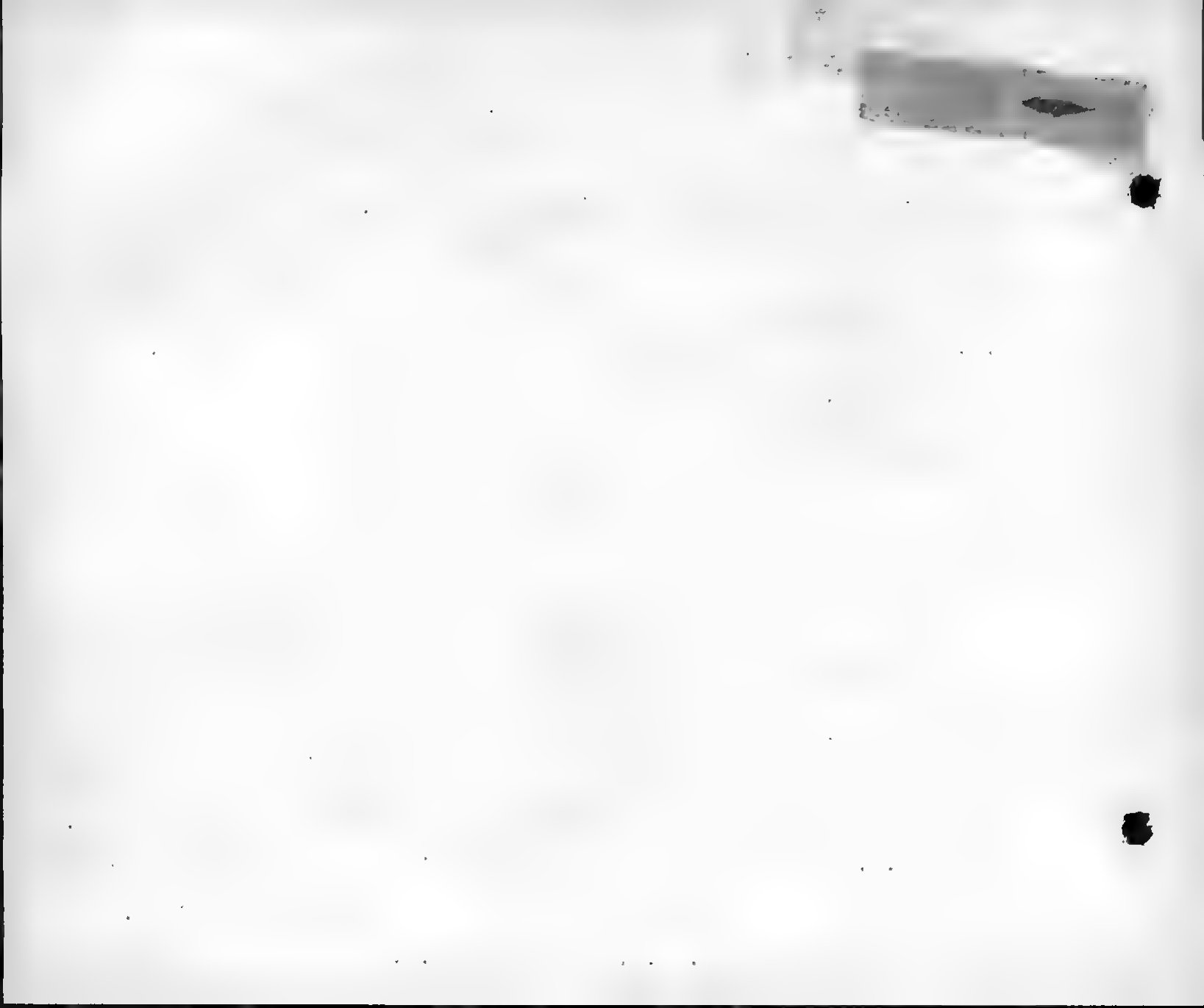
Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		d. STREET ADDRESS <b>701 19th St. N.W.</b>	
3 NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Philip</b> Last <b>ILLIG</b>		4 DATE OF DEATH Month <b>September</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-10-93</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	11. BIRTHPLACE (State or foreign country) <b>Conn.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Rudolph ILLIG</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Marie MASSEY</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO <b>WWII</b>		INFORMANT <b>Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary edema, acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause est. (b) <b>Co pulmonale</b> DUE TO (c) <b>Carcinoma, bronchogenic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 men</b> <b>1 year</b> <b>?</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 Sept. 19 59</b> to <b>28 Sept. 19 59</b> that I last saw the deceased alive on <b>28 September, 19 59</b> , and that death occurred at <b>0:25 A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>9-28-</b> ACTUAL SIGNATURE <b>V.N. HOUK</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b> PHYSICIAN'S NAME (Type) <b>V.N. HOUK LT MC USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-1-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>East Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>East Haven Conn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chamber 1400 Chapin St. N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>OCT 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kline</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. \_\_\_\_\_ may be relied upon by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~move~~ carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/5B





10454

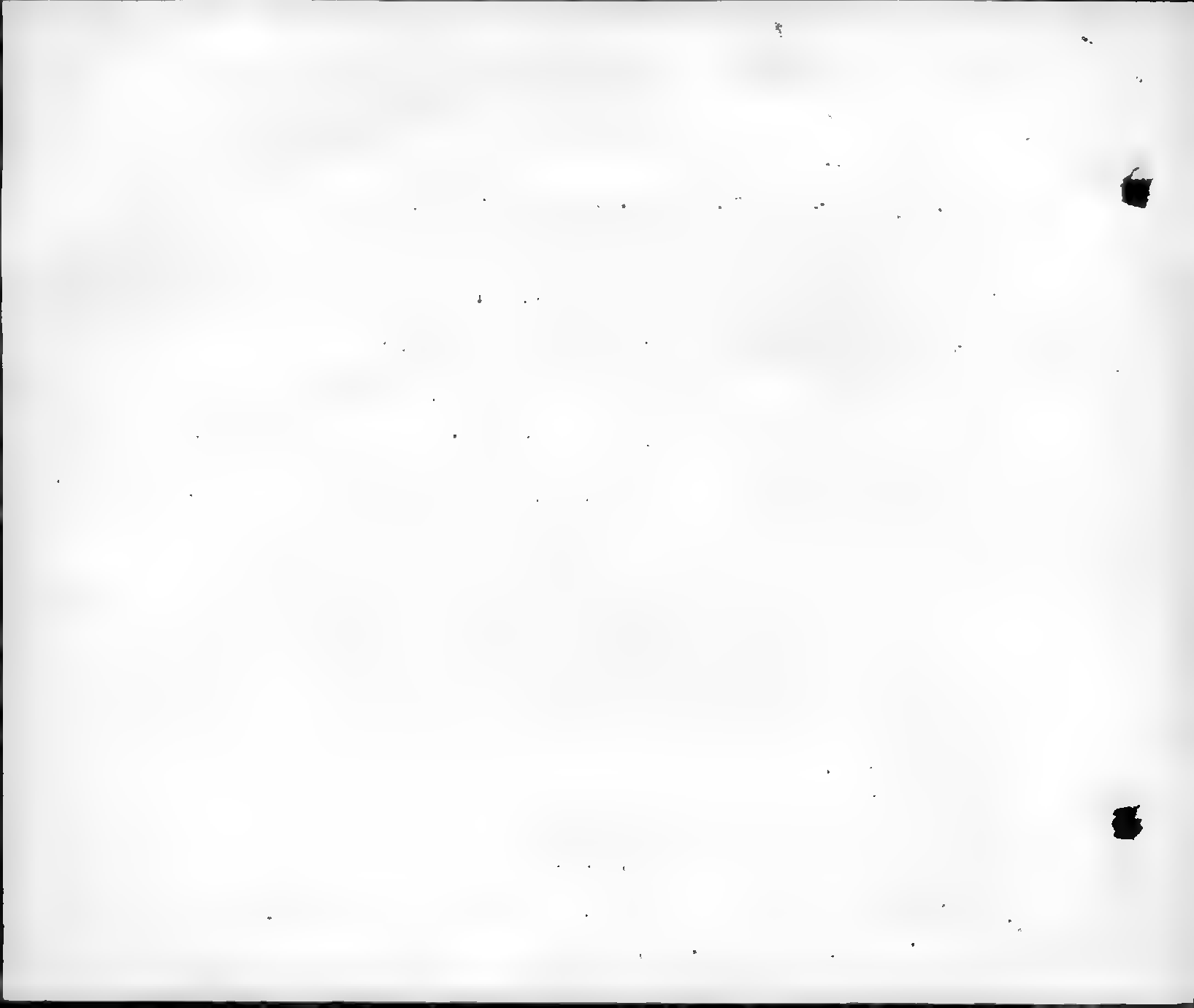
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH - a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5718 McKinley St, Bethesda, Md.</u>		e. d. STREET ADDRESS <u>5718 McKinley Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Laurence</u> Middle <u>D</u> Last <u>Jennings</u>		4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1903</u>
9. AGE (In years last birthday) <u>56</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>2</u> Days <u>29</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Statistical Economist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jack C. Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Anna G. C. Jennings</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Bertha W. Jennings-Same Item #2</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4. DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1959</u> to <u>9/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/10</u> , 19 <u>59</u> , and that death occurred at <u>4:33 AM</u> , from the causes and on the date stated above. (Seen by Dr. William Howell on 9/10/59.) ADDRESS (Street city or town state) <u>Washington Clinic, Wash 15</u> DATE SIGNED <u>9/12/59</u>			
ACTUAL SIGNATURE <u>Edward W. Youngblood</u> M.D.		PHYSICIAN'S NAME (Type) <u>Edward W. Youngblood, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9/14/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10418

Reg. Dist. No.

10455

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8600 Manchester Rd</u>				d. STREET ADDRESS <u>8600 Manchester Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Estelle Calise Jerusalem</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22 1893</u>	9. AGE (In years, last birthday) <u>66 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cosmetics retail</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Aick</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Donald Jerusalem</u> Address <u>2009 Dayton St Silver Spring md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>911.1</u> IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Inhalation of smoke &amp; fumes</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>4:20 p.m. 9-21-1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Silver Spring monty</u> (County) <u>md</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				DATE SIGNED <u>9-21-59</u>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept 24 '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S NAME (Type) <u>John J. ...</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
25. ADDRESS <u>254 CARROLL ST. N.W.</u>				26. DATE <u>SEP 23 '59</u>		27. SIGNATURE <u>  </u>	

MEDICAL CERTIFICATION

THIS MEDICAL EXAMINER'S CERTIFICATE should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



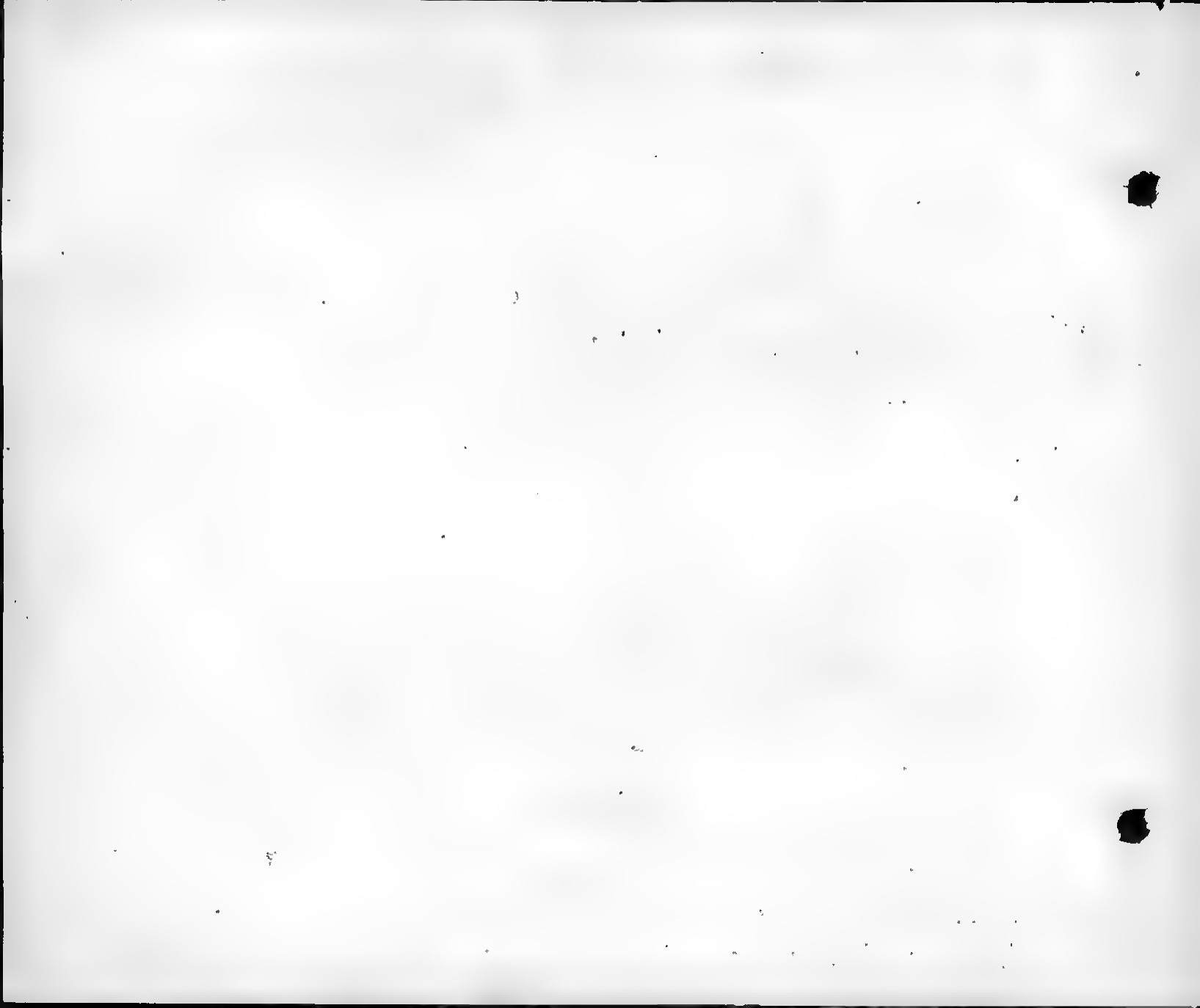
10456

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>11707 Berwick Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>George Edward Jetter</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/19/28 79</u>		9. AGE (In years last birthday) <u>79 83</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN XXXXXXXX FORMAN XXXXXXXX</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>LOCKIN CO.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Edward Jetter</u>				14. MOTHER'S MAIDEN NAME <u>E. Nunn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>071-05-1831</u>			
INFORMANT <u>Eleanor Jetter, 11707 Berwick, Silver Spring, Md.</u>				Address			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO (b) <u>Post-operative prostatectomy</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>9/12</u> to <u>9/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/22</u> , 19 <u>59</u> , and that death occurred at <u>5pm</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>909 PERSHING DRIVE, S.S.</u> DATE SIGNED <u>Arthur J. Willets</u>							
ACTUAL SIGNATURE <u>Arthur J. Willets</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILETS</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>9/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FOREST LAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BUFFALO, NEW YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Raska</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Willets</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10457

## CERTIFICATE OF DEATH

Reg. Dist. No.

10420

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hr - 44m.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Johnson</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 19 - 1899</u>
9. AGE (In years lost birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Sweden</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Gustav Breckenberg</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service: <u>  </u> )	
16. SOCIAL SECURITY NO. <u>  </u>		INFORMANT Address <u>Eleanor C. Lind - Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>CORONARY ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 HOURS</u> <u>8 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>VIRUS PNEUMONIA WITH PLEURAL EFFUSION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>  </u> <u>19</u> Hour o. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 5</u> , 19 <u>59</u> , to <u>Sept 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 11</u> , 19 <u>59</u> , and that death occurred at <u>11:59 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph O'Connor</u> M.D.		ADDRESS (Street, city or town, state) <u>9420 Old Kensington Rd</u> DATE SIGNED <u>11 Sept 59</u>	
PHYSICIAN'S NAME (Type) <u>Joseph O'Connor</u>		<u>Bethesda 14. Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>9/13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Briton, Conn.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>1331 E. Monte. Ave. Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William J. Thomas</u>		24c. REGISTRAR'S SIGNATURE	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10421

Reg. Dist. No.

10458

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shawsville</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>John Lawrent, office</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German Town</u> d. STREET ADDRESS <u>Rt. 1 # 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Gloria Louise Johnson</u> <b>4. DATE OF DEATH</b> Month Day Year <u>Sept 22 1959</u>				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1-11-59</u> <b>9. AGE</b> (in years last birthday) yrs. <u>8</u> <b>IF UNDER 1 YEAR</b> Months <u>11</u> <b>IF UNDER 24 HRS.</b> Hours <u>11</u> Min. <u></u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u></u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>R. Wiley Johnson</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Doris Bever</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u></u> <b>17. INFORMANT</b> <u>Wiley Johnson, Germantown Md.</u> Address <u></u>					
<b>18 CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Asphyxia</u>  <b>DUE TO</b>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b)</b> <u>Upper Respiratory Infection</u>  <b>DUE TO</b>  <b>(c)</b> <u></u> </div> <div style="width: 15%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>sudden</u> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u></u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u> <b>20f. (City or town)</b> (County) (State) <u></u>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Brosch</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>9-22-59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>9-24-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Methodist</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Clarkburg Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William B. Hillen, Barnesville, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>SEP 29 '59</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur B. Thomas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Give Page 4 to the funeral director. The Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File page 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10422

Reg. Dist. No.

1. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Montgomery</u> MARYLAND				a. STATE <u>Md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs</u>				d. STREET ADDRESS <u>8320 Yule Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8320 Yule Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lewis C. Jones</u>				4. DATE OF DEATH Month Day Year <u>Sept 27 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 7, 1904</u>	
9. AGE (In years last birthday) <u>55 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>NE</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Lewis Carr</u>				14. MOTHER'S MAIDEN NAME <u>Ira Carr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Glen Ham</u>				Address <u>3233 Normount Ave. Baltimore 16, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cervical occlusion</u> DUE TO <u>4-20-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to</u> DUE TO (c) <u>due to</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Blersch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Blersch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-27-59</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Damascus, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molerworth</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur H. Kline</u>	

MEDICAL CERTIFICATION



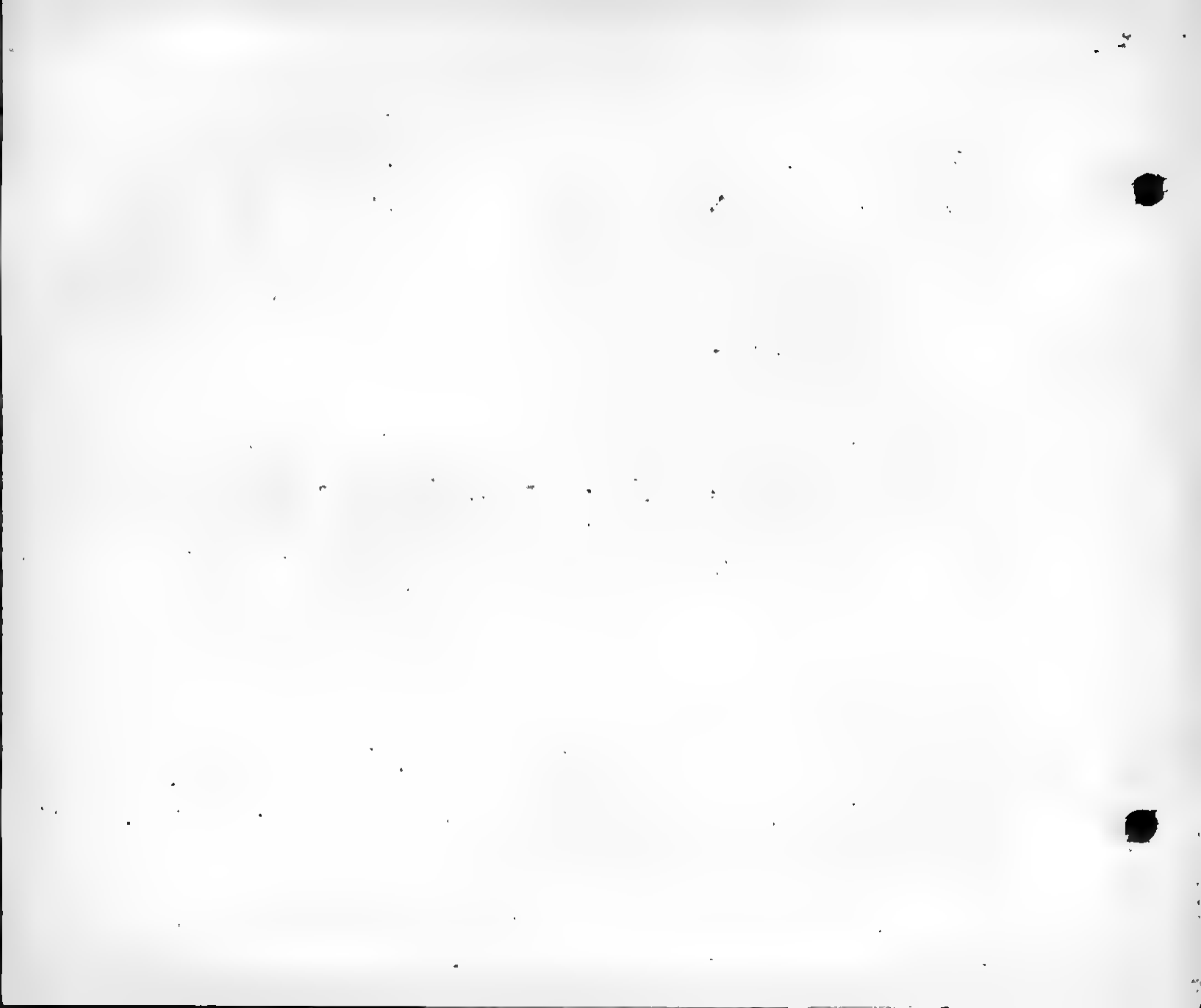
10357

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>75th</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>South Hills - Pittsburgh</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp</u>		d. STREET ADDRESS <u>536 Oxford Blvd</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Stravisko</u> Last <u>Karcis</u>		4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-81</u>
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Czech</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>John S. Karcis</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Acute endocarditis with thrombosis and abscess formation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Abscess formation and infarction of spleen and kidneys</u> (c) <u>days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-11-59</u> , 19 <u>59</u> , to <u>9-6-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-6-59</u> , 19 <u>59</u> , and that death occurred at <u>12:25</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard L. Clepp</u> M.D.		ADDRESS (Street, city or town, state) <u>1601 Carroll Hill Takoma Park, Md.</u> DATE SIGNED <u>9-7-59</u>	
PHYSICIAN'S NAME (Type) <u>Richard L. Clepp</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-7-1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Jefferson Memorial Park</u>		22d. LOCATION (City, town or county) (State) <u>Pittsburgh, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawler's Sons, Wash. DC</u>		24a. REC'D BY REGISTRAR <u>SEP 9 59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10424

Reg. Dist. No.

10460

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6 Russell Ave</b>				d. STREET ADDRESS <b>6 Russell Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>Sherwood</b> Last <b>Kingsley</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/2/1877</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Mass</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elbridge Kingsley</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Sherwood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknowns) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Clarice Griffith (daughter)</b> Address <b>Item 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>9/19/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>9-21-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank J. Broschart</b>				ADDRESS <b>6 Russell Ave Gaithersburg Md</b>		24a. REC'D BY REGISTRAR <b>SEP 22 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. J. Jones</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## CERTIFICATE OF DEATH

Reg. Dist. No.

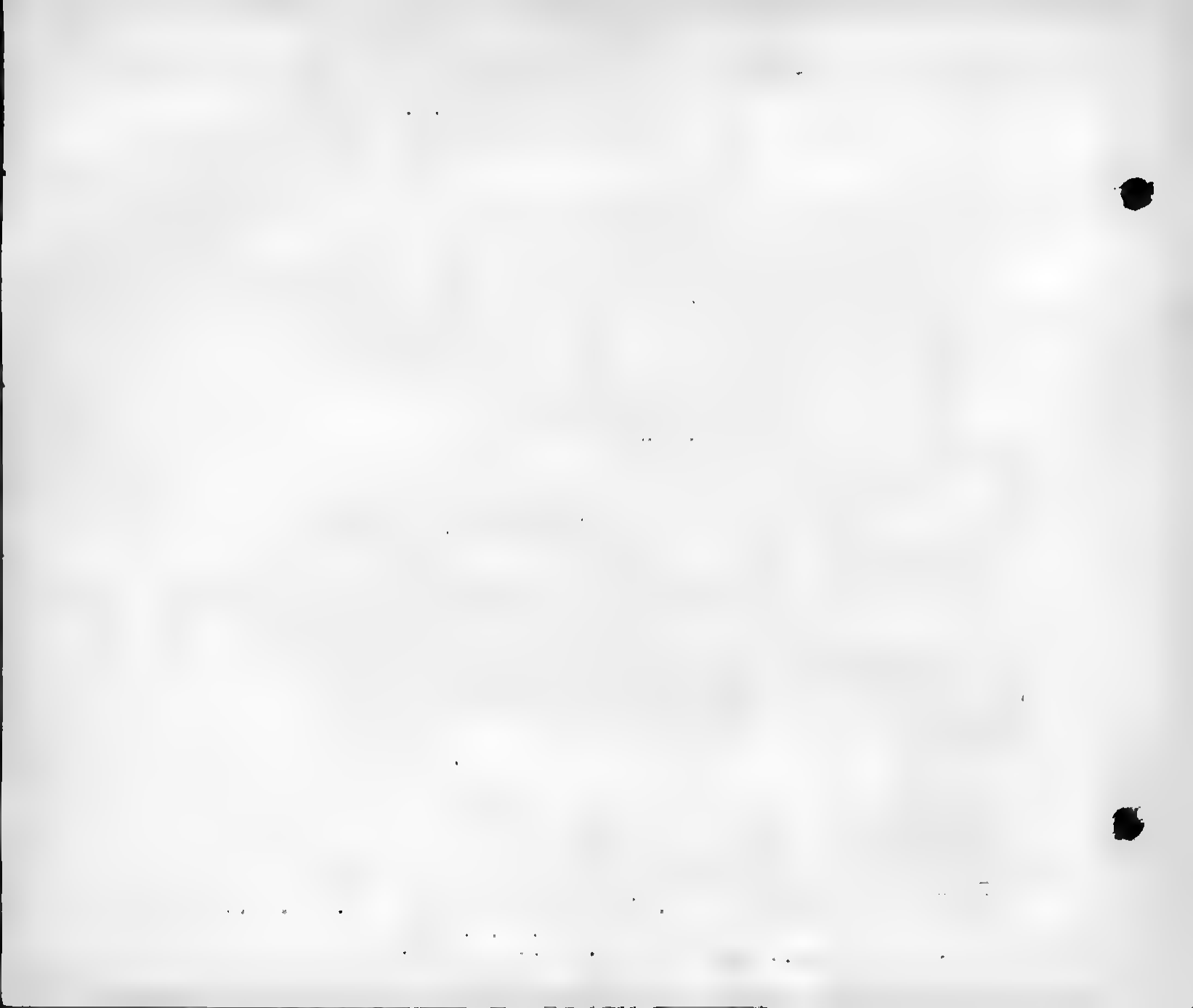
10425

10461

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>				d. STREET ADDRESS <u>2818 Rittenhouse St. Washington D.C.</u>			
3. NAME OF DECEASED (Type or print) <u>Berenice Eva Kirby</u>				4. DATE OF DEATH <u>September 12 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 8, 1878</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ambrase Patten</u>				14. MOTHER'S MAIDEN NAME <u>Eva Gaspard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>521-28-2216</u>		17. INFORMANT <u>Mrs. Genevieve Angel</u> Address <u>Washington, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4:20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH: <u>15 min.</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>Sept 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> A.M., from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Robert B. Harell</u>				ADDRESS (Street, city or town, state) <u>5516 Nebraska Ave Washington D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Harell</u>				DATE SIGNED <u>9-12-59</u>			
22a. MANNER OF DEATH: CREMATION, BURIAL, OR OTHER (Specify) <u>cremation</u>		22b. DATE THEREOF <u>9/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.,</u>				24. REC'D BY REGISTRAR <u>SEP 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10462

## CERTIFICATE OF DEATH

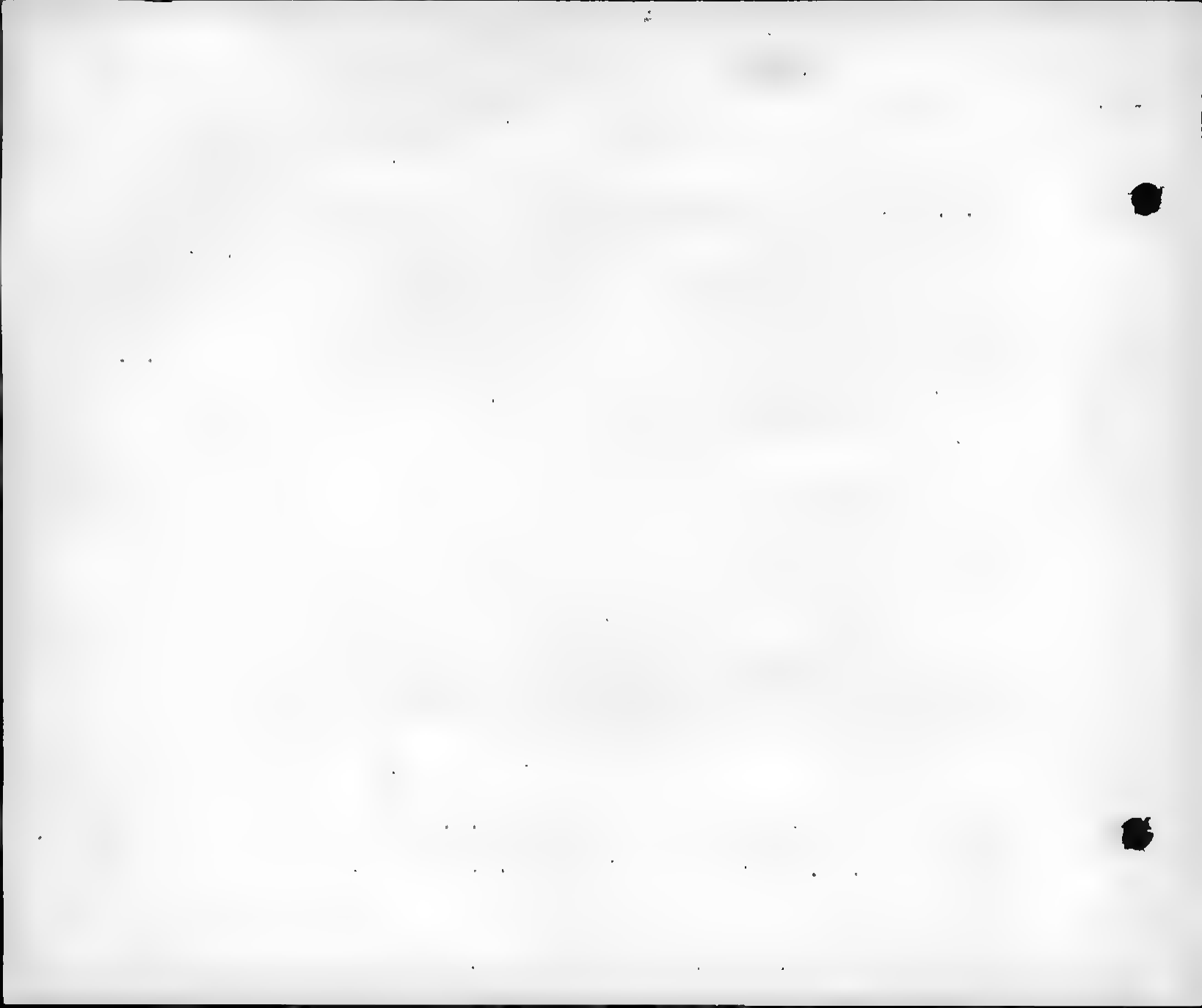
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>8 1/2 hours</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>1109 Lewis Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cecelia Irene KOVARIK</b>		4. DATE OF DEATH Month Day Year <b>September 26 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-25-59</b>
9. AGE (In years last birthday) <b>8</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>8 30</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clifford Vincent KOVARIK</b>		14. MOTHER'S MAIDEN NAME <b>Juanita Joanne GOVAI</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Clifford Vincent KOVARIK</b>		Address <b>Same as 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apnea</b> <b>776 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>8 1/2 hours</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 Sept 1959</b> to <b>26 Sept 1959</b> that I last saw the deceased alive on <b>26 Sept 1959</b> and that death occurred at <b>1:30 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md</b> DATE SIGNED <b>9-26-59</b>			
ACTUAL SIGNATURE <b>Kenneth W. Sell</b> M.D.		PHYSICIAN'S NAME (Type) <b>K. W. SELL LT MC USN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-28-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Spring Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> 1331 E. Montgomery Ave. ADDRESS <b>Rockville, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 30 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051274XV5



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10427

10463

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Alle.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Noewood Rd.</b>				d. STREET ADDRESS <b>11 S. Lee St.</b>			
3. NAME OF <b>Marie E. Lashley</b> (Type or print) First Middle Last				4. DATE OF DEATH Month Day Year <b>Sept 6, 1959 19</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/14/1900</b>		9. AGE (In years last birthday) <b>59</b> yrs.	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Geo. Wagner</b>				14. MOTHER'S MAIDEN NAME <b>Costelle Martz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Walter Lashley</b>		Address <b>Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>4541</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b> <b>4 mo.</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>9/6/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-1-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 10 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			



10464

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>--</b> b. COUNTY <b>--</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3000 McComas Avenue Kensington Gardens Nursing Home</b>		d. STREET ADDRESS <b>1409 Buchanan Street, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOSEPH E. LEAMAN</b>		4. DATE OF DEATH Month <b>SEPT</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAU.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>88</b> yrs		IF UNDER 1 YEAR: Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>JAMES E. LEAMAN</b>		14. MOTHER'S MAIDEN NAME <b>MATILDA GLOYD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>?</b>	
INFORMANT <b>Records at Nursing Home-Kensington, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PASSIVE CONGESTION OF HEART</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)		INTERVA. BETWEEN ONSET AND DEATH <b>15 MIN</b> <b>10 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a) <b>GENERALIZED ARTERIOSCLEROSIS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUG 6</b> , 19 <b>59</b> , to <b>SEPT 20</b> , 19 <b>59</b> that I last saw the deceased alive on <b>SEPT 17</b> , 19 <b>59</b> , and that death occurred at <b>4:53 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4501 CONN AVE D.C.</b> DATE SIGNED <b>9/20/59</b> ACTUAL SIGNATURE <b>Robert S. Poole</b> M.D. PHYSICIAN'S NAME (Type) <b>ROBERT S. POOLE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.-2901 14th St., N.W.</b>		24a. REC'D BY REGISTRAR <b>SEP 23 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10429

10358 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
TOWN <u>Takoma Park</u>				TOWN <u>Takoma Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>517-Albany Ave.</u>				STREET ADDRESS (If rural give location) <u>517-Albany Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>LUCY</u> (Middle) <u>REBECCA</u> (Last) <u>LEECH</u>				SEPT. 30, 19 <u>59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov. 20, 1875</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months <u>10</u> Days <u>10</u>	Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Ephraim Carlos Merriam</u>				14. MOTHER'S MARDEN NAME <u>Helen Wirt White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Tim Linville - Schenectady, N.Y.</u>			
				Nephew			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
450.0 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>						<u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterio-sclerosis</u>						<u>Indefinite</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 12, 1955</u> to <u>Sept. 30, 1959</u> , that I last saw the deceased alive on <u>Sept. 30, 1959</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>M.D. 1711 1st St. NW, Wash. 12</u>		DATE SIGNED <u>9/30/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10/5/1959</u>		NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>401 Hysong Co. - Wash. D.C.</u>	
DATE <u>OCT 5 2 '59</u>							



## CERTIFICATE OF DEATH

Reg. Dist. No. 25

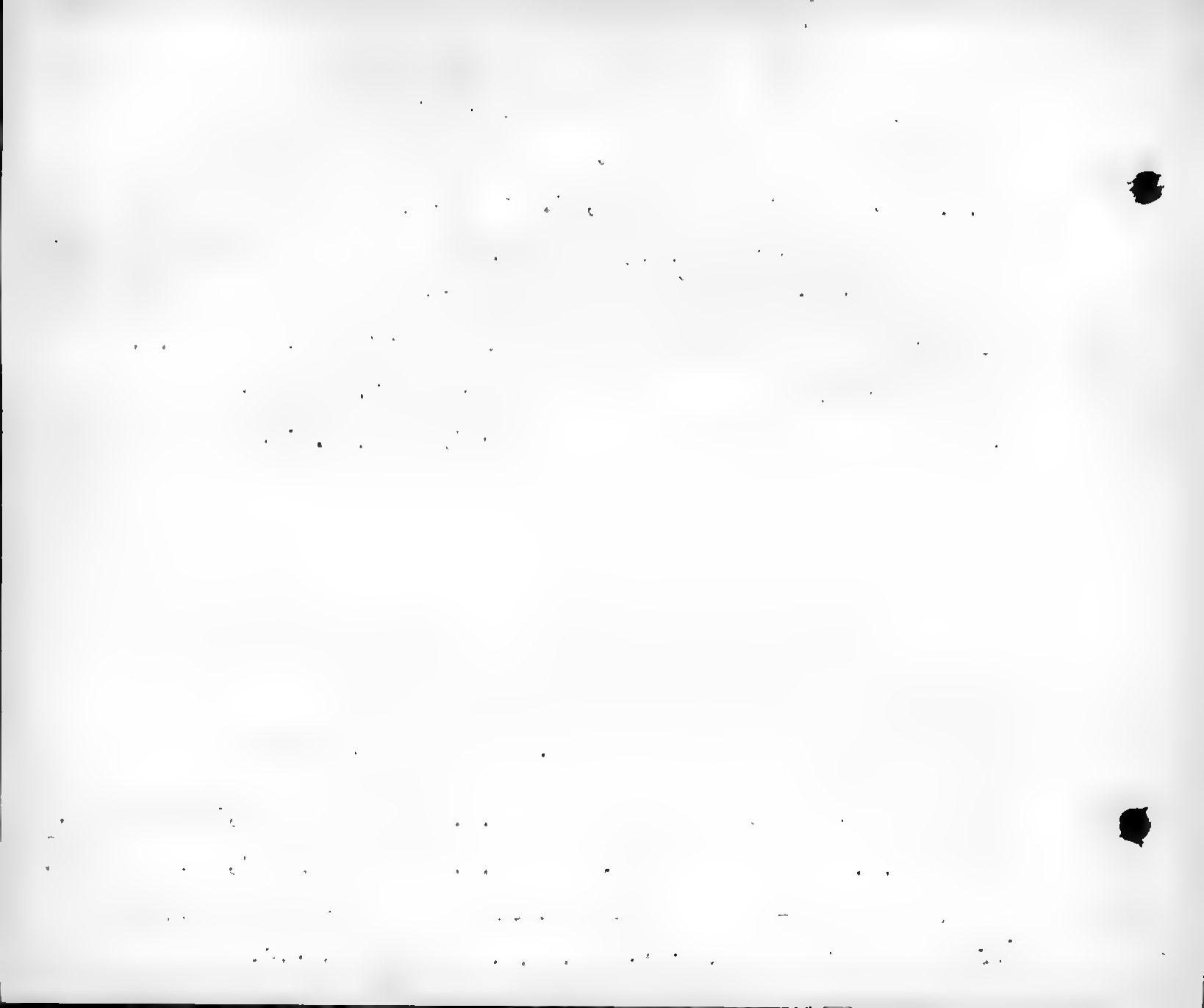
10465

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>		d. STREET ADDRESS <b>7612 Kedron Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Shirley Virginia LELAND</b>		First Middle Last		4. DATE OF DEATH <b>September 5 19 59</b>		Month Day Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 January 1924</b>	
9. AGE (In years last birthday) <b>35</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Arthur MANDERS</b>		14. MOTHER'S MAIDEN NAME <b>Virginia N. GRATHERAL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		INFORMANT <b>(Husband) Harry E. LELAND</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the breast</b> DUE TO (c) <b>2 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour <b>0</b> m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>26 Aug. 19 59</b> to <b>5 September 59</b> and that death occurred at <b>3:12 PM</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b>		DATE SIGNED <b>9-5-59</b>			
ACTUAL SIGNATURE <b>C.W. Bramlett</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>		PHYSICIAN'S NAME (Type) <b>C.W. BRAMLETT LT MC USN</b>		U.S. Naval Hospital, Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE Funeral Home</b>		ADDRESS <b>4th &amp; Mass Ave. N.E. Washington, D.C.</b>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10466

Item 5 Film 6249 9-23-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4712 Overbrook Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Lewis</u> Last <u>Lembcke</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-18-86</u>	
9. AGE (in years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Ret. Art. Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>M-S-C</u>	
13. FATHER'S NAME <u>Edward</u> <u>Glanville Coneger</u>				14. MOTHER'S MAIDEN NAME <u>Clara Tippet</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>578-14-6411</u>		17. INFORMANT <u>Robert Lembcke</u> Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>4341</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P. ...</u> ADDRESS <u>1726 ...</u>				24a. REC'D BY REGISTRAR <u>SEP 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10467

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Henrietta</b> Middle <b>LESTER</b> Last				4. DATE OF DEATH Month <b>September</b> Day <b>11</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>9-17-11</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>			
13. FATHER'S NAME <b>Thomas TROUTMAN</b>				14. MOTHER'S MAIDEN NAME <b>Georgia LAUREL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>518X</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO <b>atelectasis of Broncho-pulmonary Fistula + Rt. Lower Lobe</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept. 2</b> , 19 <b>59</b> , to <b>Sept. 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 11</b> , 19 <b>59</b> , and that death occurred at <b>2:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>9-12-59</b> ACTUAL SIGNATURE <b>R. G. Muth</b> M.D. PHYSICIAN'S NAME (Type) <b>R. G. MUTH, LT, MC, USN</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial-Shipment 9-14-59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Montezuma Georgia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Snowden Funeral Home, Rockville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 16 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur B. Harris</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

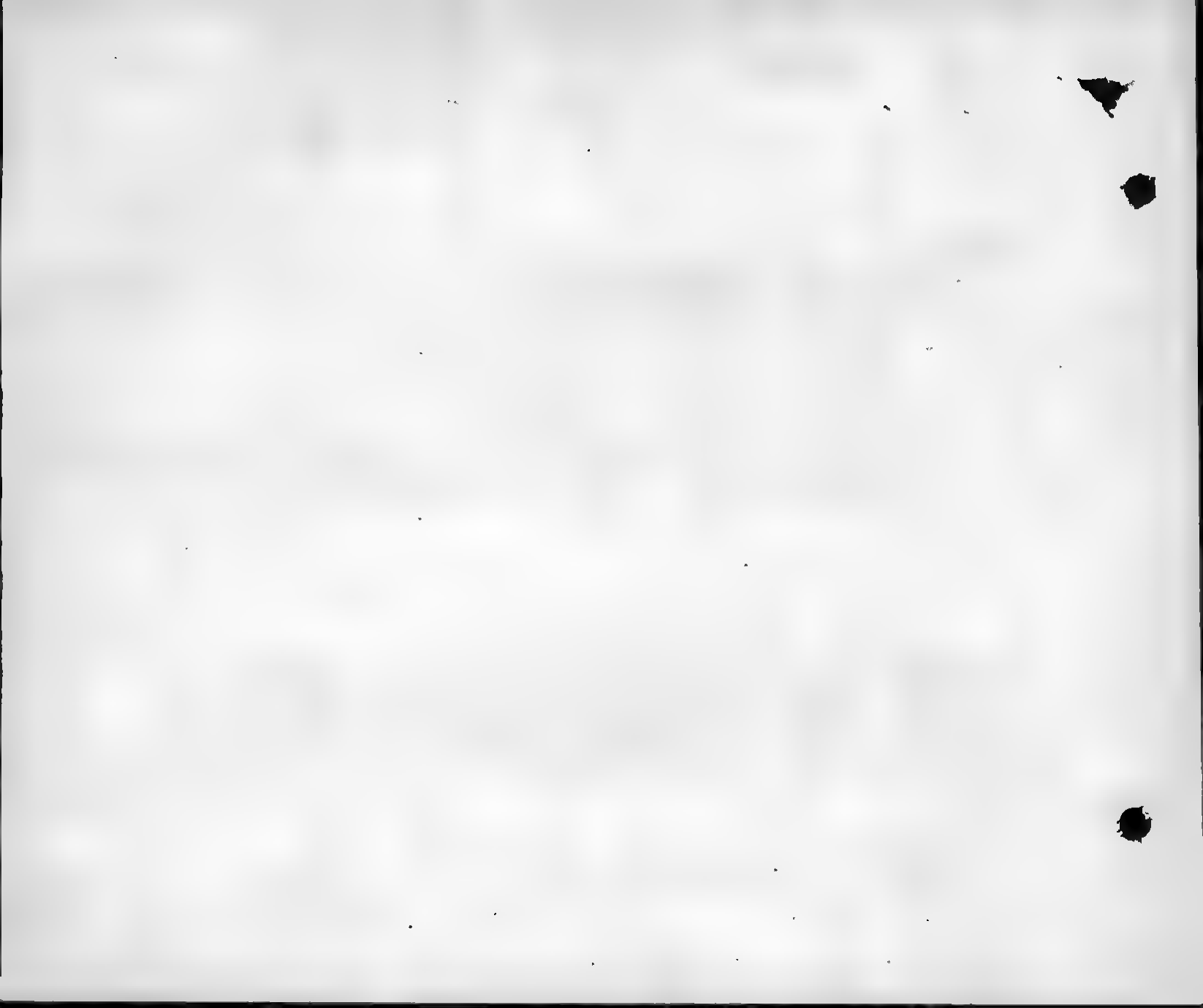
10468

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 da -</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Route #1 Travilah Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Peggy Sue Liker</u>				4. DATE OF DEATH Month Day Year <u>9 20 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-54</u>		9. AGE (in years last birthday) yrs. <u>5</u> Months <u>2</u> Days <u>2</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Liker</u>				14. MOTHER'S MAIDEN NAME <u>Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Rockville Md</u> <u>Elinora Williams Rt #1 Travilah Road</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>717.0</u> DUE TO <u>Asphyxiation from morbid</u> Conditions, if any, which gave rise to immediate cause (b) <u>Injury from</u> (a), stating the underlying cause last, DUE TO <u>1st - 2nd &amp; 3rd degree burns (35%)</u> (c) <u>Enterococci</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 days</u> <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Enterococci</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child pulled from hot water oven self</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>11:40 PM 9-15 1959</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rockville Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-21-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey - Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 24 59</u>		24b. REGISTRAR'S SIGNATURE <u>C. E. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9VVVVVVXUL



10359

## CERTIFICATE OF DEATH

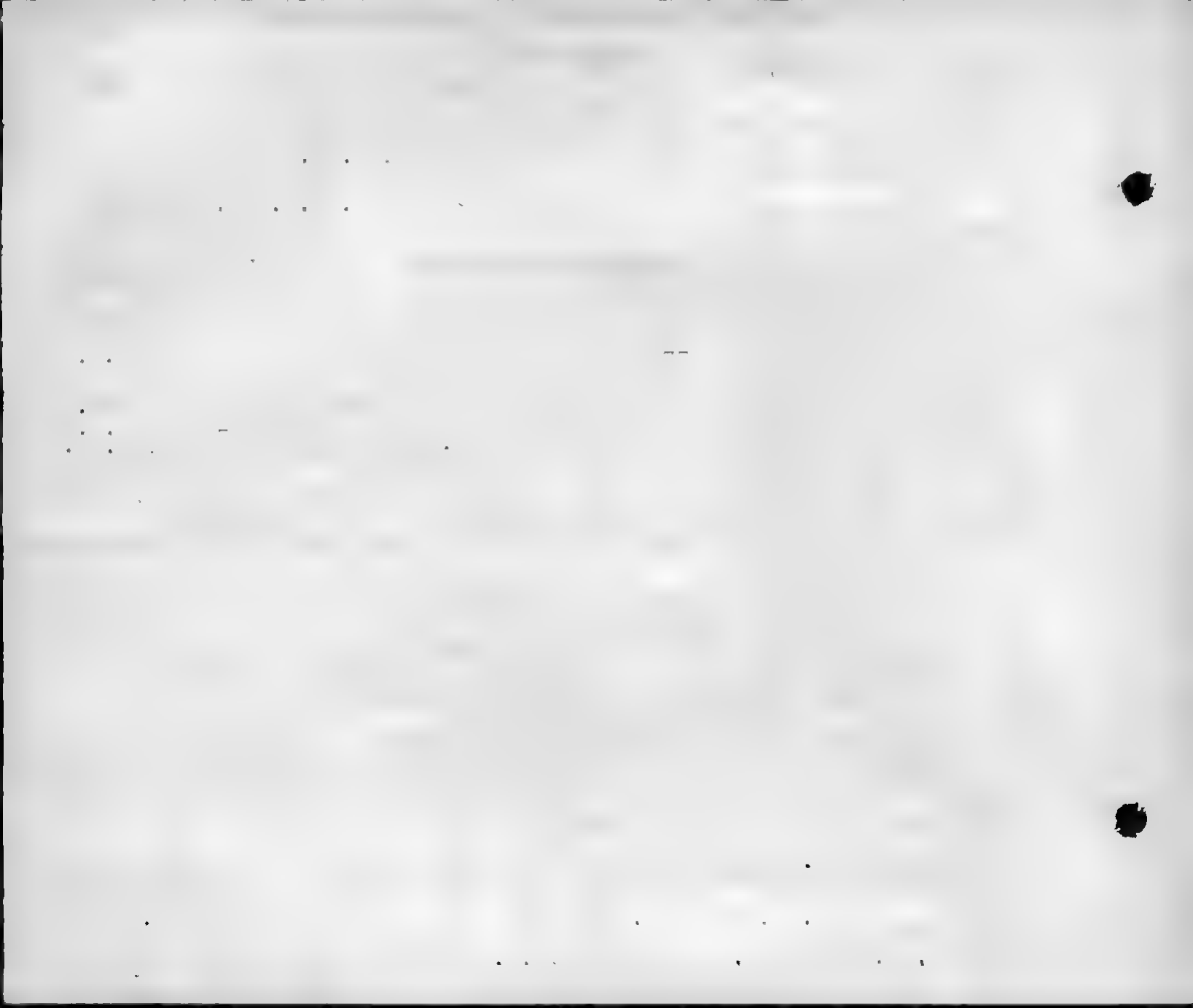
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>Washington, D. C.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7300 Baltimore Ave</b>				d. STREET ADDRESS <b>3420 -16th St. N.W. Apt. 303</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Grace MacCurdy</b>		4. DATE OF DEATH <b>Sept 13 1959</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/19/1878</b>		9. AGE (In years last birthday) <b>81</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Johnston</b>		14. MOTHER'S MAIDEN NAME <b>Laura Williams</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Joseph F. MacCurdy</b>		Address <b>3420 -16th St. N.W. Washington, D. C.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Constrictive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hiatal Hernia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr 10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>August 4 1959</b> to <b>Sept 13 1959</b> , that I last saw the deceased alive on <b>Sept 13 1959</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James M. Whitlock</b>		M.D. <b>2701 Carroll Ave</b>		DATE SIGNED <b>9-13-59</b>		ADDRESS (Street, city, town, state) <b>Takoma Park Maryland</b>	
PHYSICIAN'S NAME (Type) <b>James M. Whitlock</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 16, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
22d. LOCATION (City, town, or county) <b>Prince Georges Co. Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William L. Hines</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>	
ADDRESS <b>Washington, D.C.</b>		DATE					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

10435

Reg. Dist. No.

10469

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. STREET ADDRESS <u>Rt #3 (The Woodlands)</u>			
3. NAME OF DECEASED (Type or print) <u>(Infant) PATRICIA DENISE MADINE</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/16/59</u>	
9. AGE (In years last birthday) <u>10 days</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>		IF UNDER 24 HRS Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>md - (Bethesda)</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>JAMES J. MADINE</u>				14. MOTHER'S MAIDEN NAME <u>Helen Augusta Caulfield</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>---</u>		INFORMANT <u>Chart. (Hosp. Records)</u> Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> <u>7545</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital Heart Anomaly</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a m p m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 16, 1959</u> to <u>Sept 25, 1959</u> , that I last saw the deceased alive on <u>Sept 25, 1959</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. H. Bergstrom</u>		M.D. <u>Rockville Medical Center</u>		DATE SIGNED <u>9-25-59</u>			
PHYSICIAN'S NAME (Type) <u>Rockville, Md.</u>							
22a BURIAL, CREMATON REMOVAL (Specify) <u>Burial</u>		22b DATE THEREOF <u>9/28/59</u>		22c NAME OF CEMETERY OR CREMATORY <u>Cloppers, Md.</u>		22d LOCATION (City, town, or county) (State) <u>Gaithersburg MD. RAD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>---</u> ADDRESS <u>Gaithersburg, Md.</u>				24a REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>		24b REGISTRAR'S SIGNATURE <u>William E. Kraus</u>	

2074212XU4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10435

Reg. Dist. No.

10374

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN TB <u>8 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glen Rd</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <span style="float: right;">(Rural)</span> d. STREET ADDRESS <u>Glen Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary Florence Indian Eve Marks</u> First Middle Last <b>4. DATE OF DEATH</b> Month <u>Sept</u> Day <u>25</u> Year <u>1959</u>				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>2-9-1881</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk - Red Cross</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>md</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>md</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Wm T. Queen</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Hardy</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Frances Hallinger</u> Address <u>Stim 2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u>  <u>years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSCHEIT</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>9-25-59</u>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>9-28-59</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Congressional Cem.</u> <b>22d. LOCATION (City, town, or county) (State)</b> <u>Washington, D. C.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. K. Hartmann &amp; Son</u> <b>ADDRESS</b> <u>5737 Eu. Ave. Wash. 11</u>				<b>24a. REC'D BY REGISTRAR</b> <u>SEP 28 '59</u> <b>DATE</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur B. Kenna</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10437

Reg. Dist. No.

10360

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Pri. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b> <b>1615-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN &amp; HOSP. T.P.-12</b>		d. STREET ADDRESS <b>2111 GULFORD RD</b>	
3. NAME OF DECEASED (Type or print) First <b>DONNA</b> Middle <b>MARSHALL</b> Last <b>MARSHALL</b>		4. DATE OF DEATH Month <b>9</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>JACK B MARSHALL</b>		14. MOTHER'S MAIDEN NAME <b>VIVIAN BART</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <b>WASH SAN &amp; HOSP RECORDS</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>756.1</b> DUE TO <b>Suppurative Aneurysm &amp; aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Since birth</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 12, 1959</b> to <b>Sept 16, 1959</b> , that I last saw the deceased alive on <b>Sept 16, 1959</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lyle Williams</b> M.D.		ADDRESS (Street, city or town, state) <b>8700 Colesville Rd Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Lyle Williams</b>		DATE SIGNED <b>Sept 16, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>9/18/59</b>	<b>Forest Oak Cemetery</b>	<b>Gaithersburg Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. B. Bartner</b> ADDRESS <b>Gaithersburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 18 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur A. Friend</b>

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**10470**

**CERTIFICATE OF DEATH**

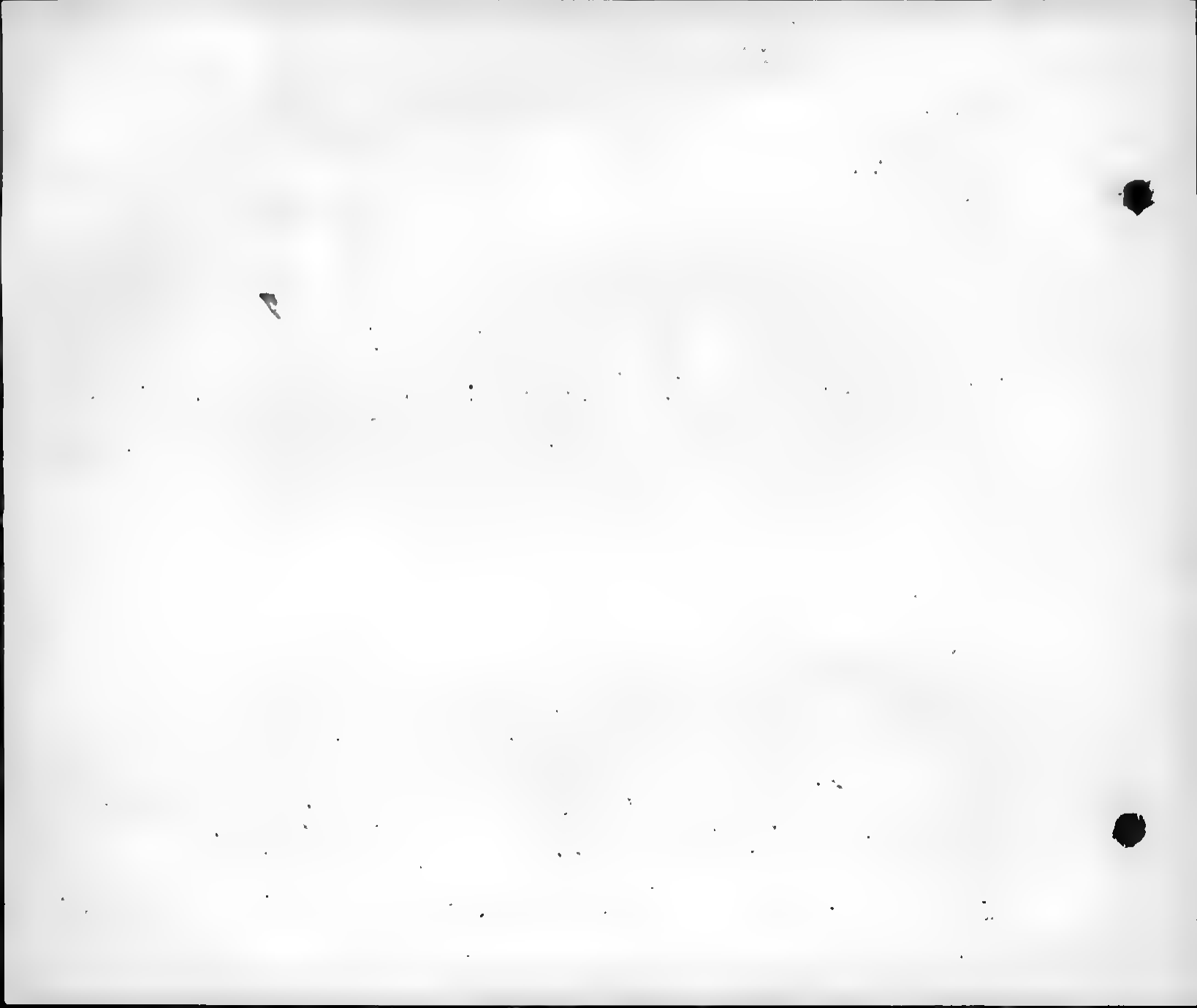
Reg. Dist. No. **10438**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
c. LENGTH OF STAY IN 1b <b>4 1/2 yrs</b>		d. STREET ADDRESS <b>303 Marvin Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>303 Marvin Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>L.</b> Last <b>Martell</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OF RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1867</b>
9. AGE (In years last birthday) <b>92 yrs</b>		10. IF UNDER 1 YEAR: Months <b>92</b> Days <b>92</b> Hours <b>92</b> Min <b>92</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker, retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Quebec, Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. Ralph S. Sadler, 303 Marvin Rd., Silver</b>		Address <b>(Spring, Md.)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic cardio-vascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>January 3, 1957</b> to <b>Sept. 26, 1959</b> that I last saw the deceased alive on <b>Sept. 26, 1959</b> , and that death occurred at <b>11:08 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Raymond Bradshaw, M.D.</b>		ADDRESS (Street, city or town, state) <b>345 University Blvd, West 9/26/59</b>	
PHYSICIAN'S NAME (Type) <b>Raymond Bradshaw</b>		DATE SIGNED <b>Silver Spring, Md.</b>	
22a. DATE OF CREMATION REMOVAL (Specify) <b>Oct. 1, 1959</b>	22b. DATE OF BURIAL <b>Burial</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>	22d. LOCATION (City, town, or county) <b>Monroe, Michigan</b> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>SEP 29 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.



MEDICAL CERTIFICATION



10375

CERTIFICATE OF DEATH

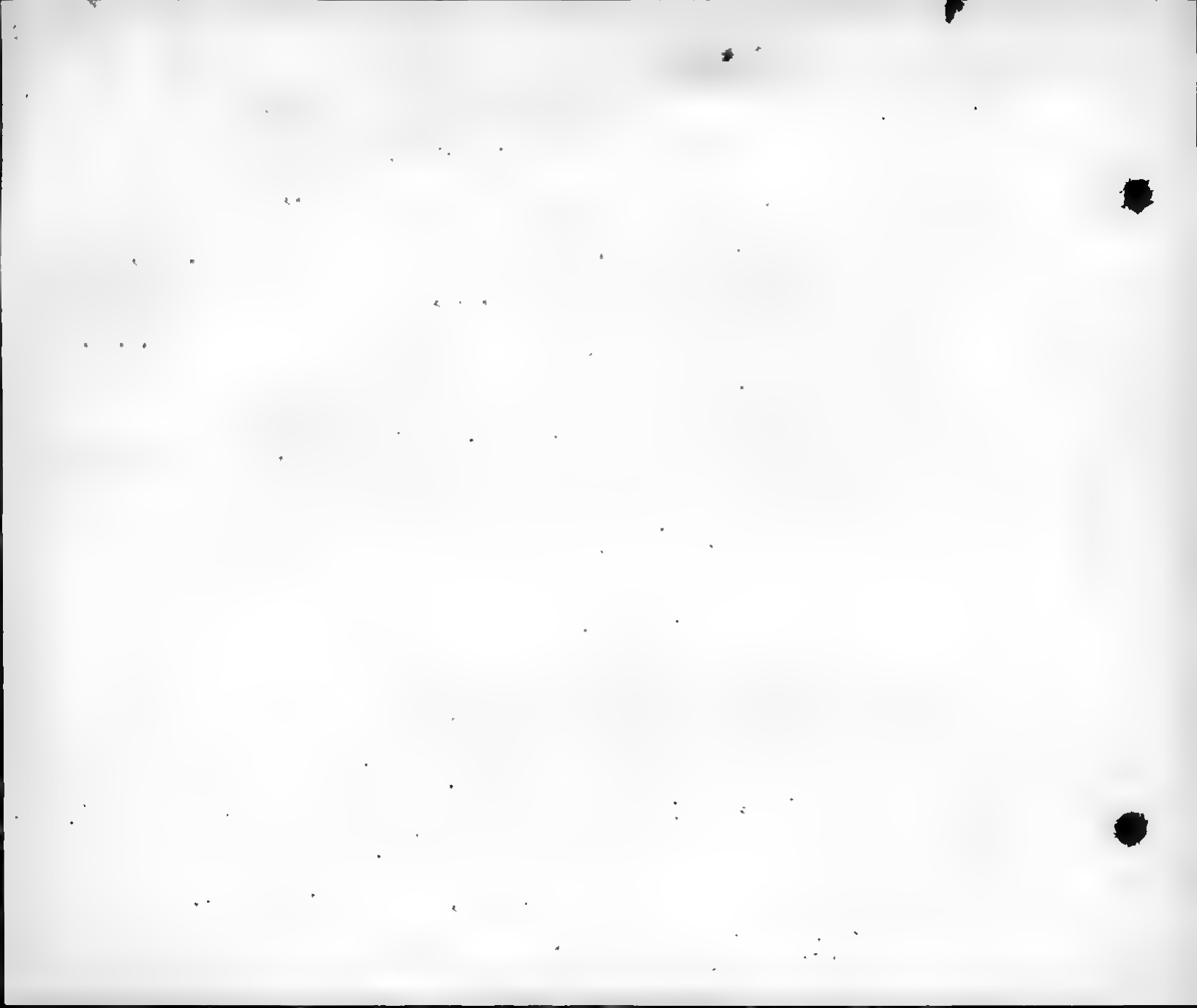
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville,</b> c. LENGTH OF STAY IN 1b <b>Rockville, M</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>114 Frederick Ave.,</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville, M</b> d. STREET ADDRESS <b>114 Frederick Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CARMEN</b> Middle <b>M.</b> Last <b>MASON</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>12,</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 15, 1904</b>	
9. AGE (In years last birthday) <b>54</b> yrs		10. UNDER 1 YEAR Months <b>64</b> Days <b>12</b> Hours <b>19</b> Min <b>59</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Charles A. Hill</b>				14. MOTHER'S MAIDEN NAME <b>Katie Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>James A. Mason</b> Address <b>Item 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable coronary occlusion</b> DUE TO (b) <b>Hypertensive cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Systolic</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 8, 1957</b> , to <b>Sept. 12, 1959</b> , that I last saw the deceased alive on <b>Sept. 11, 1959</b> , and that death occurred at <b>10 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. H. Lenthorn</b> M.D.		ADDRESS (Street, city or town, state) <b>26 N. Summit Ave.</b> DATE SIGNED <b>9/12/59</b>					
PHYSICIAN'S NAME (Type) <b>Lenthorn, H. H.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National,</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b> ADDRESS <b>Rockville, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton &amp; House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 15, Film G-243 5/24/59.cac

10441

10472

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>--</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Lincoln</b> Last <b>McBride</b>				4. DATE OF DEATH Month <b>September</b> Day <b>18</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 25, 1893</b>	
9. AGE (In years last birthday) yrs. <b>65</b>		IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Charles McBride</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Sneed</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No Yes World War I</b>				16. SOCIAL SECURITY NO <b>220-01-8565</b>			
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhagic bronchopneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>days</b>							
DUE TO (b) <b>Acute myelogenous leukemia</b> <b>3 months</b>							
DUE TO (c) <b>Subacute bacterial endocarditis, aortic valve</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>September 16, 19 59</b> , to <b>September 18, 19 59</b> , that I last saw the deceased alive on <b>September 18, 19 59</b> , and that death occurred at <b>9:50 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jerry S. Trier</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>9-19-59</b>			
PHYSICIAN'S NAME (Type) <b>Jerry S. Trier, M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Still Pond Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Still Pond Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Kennedy</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 24 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton G. Hume</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10473

## CERTIFICATE OF DEATH

10442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>17 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Summerhill</b> d. STREET ADDRESS <b>Box 205</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Jerome</b> Last <b>McCall</b>			4. DATE OF DEATH Month <b>September</b> Day <b>11</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 25, 1936</b>	9. AGE (In years last birthday) <b>23</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Thomas McCall</b>				
14. MOTHER'S MAIDEN NAME <b>Eather Noon</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO <b>210-28-7674</b>			17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> <b>197.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Malignant Carcinoma</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 Months</b> <b>1 Year</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August 25, 1959</b> , to <b>September 11, 1959</b> , that I last saw the deceased alive on <b>September 11, 1959</b> , and that death occurred at <b>3:40 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Charles E. Mengel</b>		The Clinical Center National Institutes of Health Bethesda 14, Maryland		9/11/59			
PHYSICIAN'S NAME (Type) <b>CHARLES E. MENGEL, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Temp 9-14-59</b>		22b. DATE THEREOF <b>SEP 14 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S</b>			
22d. LOCATION (City, town, or county) (State) <b>Cambria Co. Pennsylvania</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b>		ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 15 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 File G249 1-13-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

11590

10474

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NEW YORK</u> b. COUNTY <u>QUEENS</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FLUSHING NEW YORK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS SANIT.</u>		d. STREET ADDRESS <u>143-54 Roosevelt Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>D. J.</u> Last <u>McCarthy</u>		4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years lost birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Respiratory failure</u> Conditions if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Bronchus Pneumonia</u> DUE TO (c) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 days</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/28</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> A.M. from the causes and on the date stated above.		ADDRESS (Street city or town, state) <u>5707 Wisconsin Ave</u> DATE SIGNED <u>9/29/59</u>	
ACTUAL SIGNATURE <u>Frank G. Jagger Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>Chewy Chew (S, Md.)</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/29/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>New York</u>		22d. LOCATION (City, town, or county) (State) <u>N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew Thomas</u> ADDRESS <u>3831-66 Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

Handwritten text, possibly a signature or name, located in the upper right quadrant.

Handwritten text, possibly a date or a short phrase, located below the signature.

Handwritten text, possibly a signature or name, located in the lower left quadrant.

Handwritten text, possibly a date or a short phrase, located at the bottom center.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10443

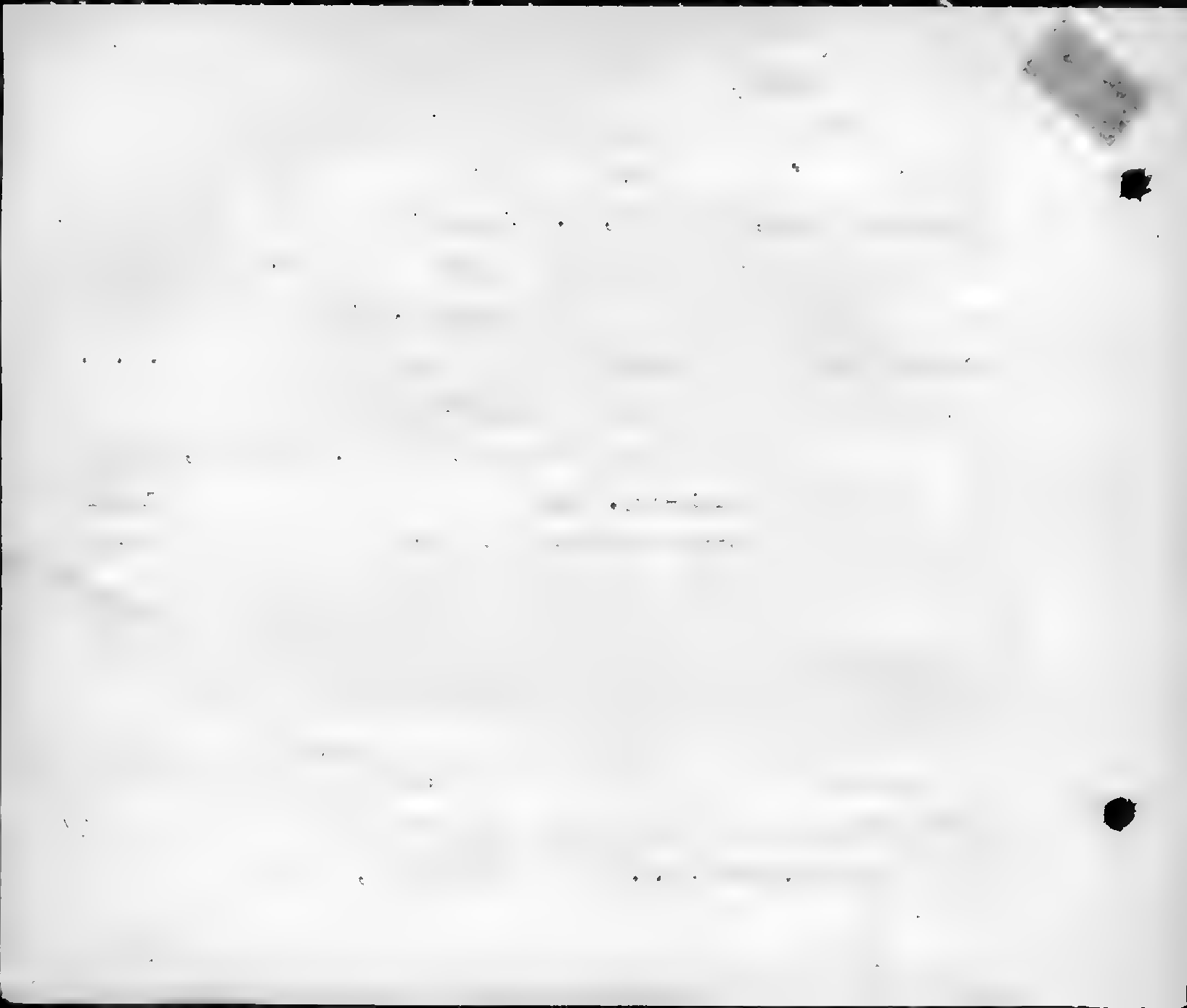
10475

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>105 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <b>Ohio</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairborn</b> d. STREET ADDRESS <b>64 North Wright Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Grover William McCoy</b>			<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>30</b> Year <b>1959</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>September 24, 1892</b>		<b>9. AGE</b> (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____ IF UNDER 24 HRS: _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Accounting Clerk</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Government (Retired)</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Ohio</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>Joseph McCoy</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Evangeline West</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>Unascertainable</b>		<b>17. INFORMANT</b> <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <table style="width: 100%;"> <tr> <td style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a) 1992</b>  <b>Cardio-resp. Arrest</b>                      DUE TO                      Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Malignant metastatic carcinoid</b>                      DUE TO (c) _____                 </td> <td style="width: 20%; vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>1 hour</b>  <b>6 years</b> </td> </tr> </table> <b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a) 1992</b> <b>Cardio-resp. Arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Malignant metastatic carcinoid</b> DUE TO (c) _____	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hour</b> <b>6 years</b>
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a) 1992</b> <b>Cardio-resp. Arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Malignant metastatic carcinoid</b> DUE TO (c) _____	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hour</b> <b>6 years</b>						
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Hour _____ a. m. _____ p. m. Month _____ Day _____ Year <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____							
<b>21. I certify that I attended the deceased from</b> <b>June 17, 1959</b> , <b>to</b> <b>September 30, 1959</b> , <b>that I last saw the deceased alive on</b> <b>September 30, 1959</b> , <b>and that death occurred at</b> <b>3:10 P. M.</b> , <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) _____ <b>DATE SIGNED</b> <b>10/1/59</b> <b>ACTUAL SIGNATURE</b> <i>Charles S. Mengel</i> M.D. <b>The Clinical Center</b> <b>PHYSICIAN'S NAME</b> (Type) <b>Charles S. Mengel, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial-transit</b>		<b>22b. DATE THEREOF</b> <b>10/1/59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Dayton, Ohio</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b>			<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>OCT 5 2 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Charles S. Mengel</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician's office. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





10476

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>18 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>371 Tucker Lane St NW</u>	
3. NAME OF DECEASED (Type or print) First <u>M</u> Middle <u>John</u> Last <u>McMill</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/9/92</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>20</u>	11. IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Printing Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printer</u>	
11. BIRTHPLACE (State or foreign country) <u>Green</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick McMill</u>		14. MOTHER'S MAIDEN NAME <u>Mary Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Army</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wife (home or away)</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Increased Intracranial Pressure</u> DUE TO <u>Cerebral injury (1st frontal lobe)</u> DUE TO <u>WDA extra-intracranial hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u> <u>6 weeks</u> <u>20 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 19, 1957</u> to <u>Sept 29, 1959</u> that I last saw the deceased alive on <u>Sept 28, 1959</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Michel M. Healy</u> M.D.		ADDRESS (Street, city or town, state) <u>Washington Clinic, Wash. D.C.</u> DATE SIGNED <u>9/29/59</u>	
PHYSICIAN'S NAME (Type) <u>Michel M. Healy</u>		<u>Washington Clinin, Wash. D. C.</u>	
22a. BURIAL, CREMAT., OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>OCI</u> DATE <u>2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10445

10477

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>474-3</u> d. STREET ADDRESS <u>1351 GIRARD ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>P</u> Last <u>McAnley</u> <b>4. DATE OF DEATH</b> Month <u>9</u> Day <u>2</u> Year <u>1959</u>				<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>C</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> ? <b>9. AGE</b> (In years last birthday) <u>45</u> yrs. <b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Librarian</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Georgia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>				<b>13. FATHER'S NAME</b> <u>Unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <u>Miss Dicks, (Postmaster)</u> Address <u>1351 Girard St. Wash. D.C.</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</b> <u>Breemia</u> DUE TO <u>Renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Chronic Injuries</u> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>4 Days</u> <u>10 Days</u>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Critical on collapse of construction job</u> <b>20c. TIME OF INJURY</b> Month <u>8</u> Day <u>22</u> Year <u>1959</u> <b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Bldg.</u> <b>20f. (City or town)</b> <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>MD</u>				<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>. Inspection <input type="checkbox"/>. Inquiry <input type="checkbox"/>. and find that death resulted from: Natural causes <input type="checkbox"/>. Accident <input checked="" type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.</b>			
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschert</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>9-2-59</u>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>9-5-59</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Lincoln Memorial</u> <b>22d. LOCATION (City, town, or county)</b> <u>Suitland Rd.</u> (State) <u>MD</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter D. Dineen</u> <b>ADDRESS</b> <u>621 Lincoln Rd.</u> <b>24a. REC'D BY REGISTRAR</b> <u>SEP 4 59</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur J. Dineen</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10446

Reg. Dist. No.

10361

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN TB <u>D.O.A.</u>				d. STREET ADDRESS <u>8423 New Hampshire Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha Virginia Michael</u>				4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-15-82</u>	
				9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Walter George Burton</u>				14. MOTHER'S MAIDEN NAME <u>Riesmeisel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Did not have one</u>			
				17. INFORMANT Address <u>Mrs. C. M. Bessi - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (a), stating the underlying cause last. DUE TO (c) <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic Mellitus (covered years)</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Sept 21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lucien</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>254 Carroll St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William B. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10478

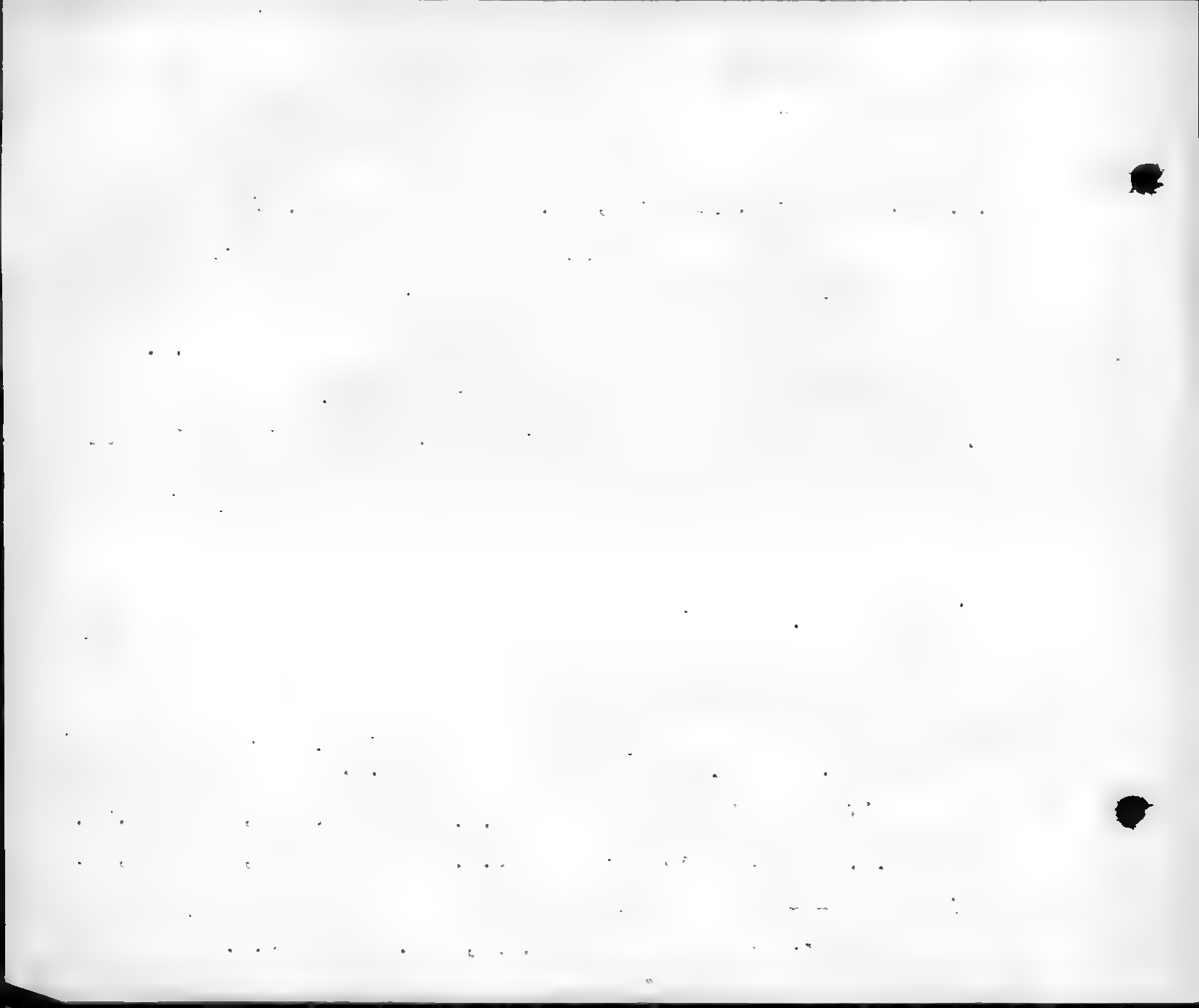
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>478</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>627 Forrester St. SE</b>			
3. NAME OF DECEASED (Type or print) First <b>Peter</b> Middle <b>Madison</b> Last <b>MINCEY</b>				4. DATE OF DEATH Month <b>September</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 May 1956</b>		9. AGE (In years last birthday) yrs. <b>3</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>child</b>		11. BIRTHPLACE (State or foreign country) <b>Hawaii</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Andrew Van MINCEY</b>				14. MOTHER'S MAIDEN NAME <b>Lavon MCDOUGALL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>C NO</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		INFORMANT Address <b>(Father) Andrew Van MINCEY Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Purulent meningitis and bacterial pneumonia</b> <b>40.3</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hydrocephalus with ventriculo-jugular shunt</b>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>31 Aug 1959</b> to <b>6 Sept. 1959</b> that I last saw the deceased alive on <b>6 Sept. 1959</b> and that death occurred at <b>1:35 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>AB Avery</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 9-7-59</b>					
PHYSICIAN'S NAME (Type) <b>G.B. AVERY, LT MC USN</b>		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chambers Funeral Home 517 11th St. SE, Washington, D.C.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 9 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.





10479

## CERTIFICATE OF DEATH

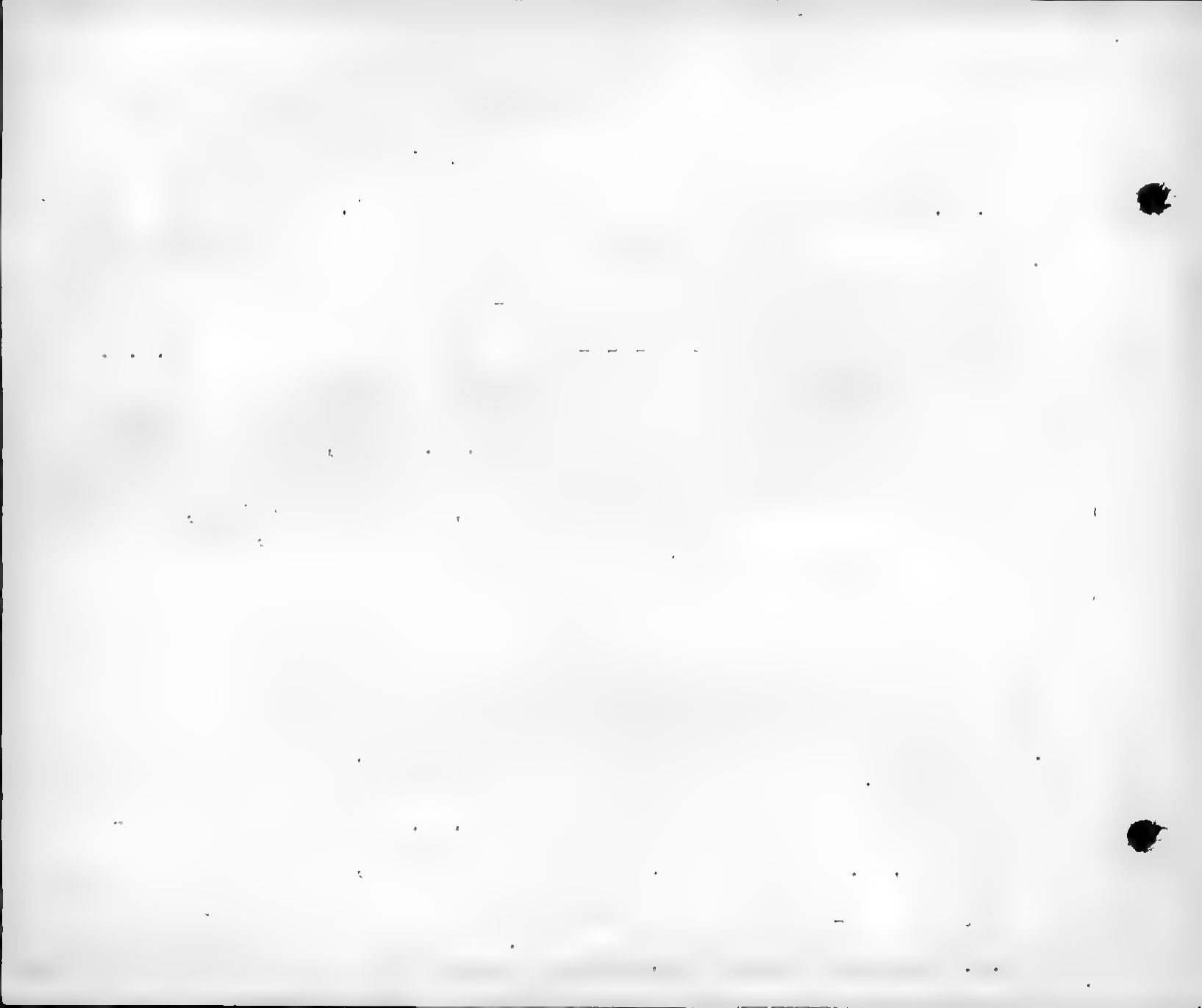
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>5719 29th St., West</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ruth</b>		Middle <b>Nelson</b>		Last <b>MOORE</b>		4. DATE OF DEATH Month <b>September</b>		Day <b>15</b>		Year <b>1959</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-11-12</b>		9. AGE (In years last birthday) <b>47</b> yrs		10. IF UNDER 1 YEAR Months <b>47</b>		11. IF UNDER 24 HRS Days <b>47</b>		12. IF UNDER 24 HRS Hours <b>47</b>		13. IF UNDER 24 HRS Min <b>47</b>		14. IF UNDER 24 HRS Min <b>47</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Chester NELSON</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte DIETZ</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(H) Geo. L. Moore, same as #2 above</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>		DUE TO (b) <b>Anaplastic carcinoma, site undetermined, with widespread metastases to lung, brain and abdominal organs</b>		DUE TO (c) <b>and abdominal organs</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>177</b>		18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>177</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>g. m.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>177</b>		20f. (City or town) <b>177</b>		(County) <b>177</b>		(State) <b>177</b>		21. I certify that I attended the deceased from <b>May 26</b> , 19 <b>59</b> , to <b>Sept. 15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 13</b> , 19 <b>59</b> , and that death occurred at <b>12:25A</b> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>		DATE SIGNED <b>9-15-59</b>	
ACTUAL SIGNATURE <b>Pauline P. Clarke</b>		M.D. <b>U. S. Naval Hospital</b>		PHYSICIAN'S NAME (Type) <b>P. E. CLARKE, LCDR, MC, USN</b>		Bethesda, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Pumphrey</b>		ADDRESS <b>Rumal Home, Silver Spring</b>		24a. REC'D BY REGISTRAR <b>SEP 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		25. I certify that I attended the deceased from <b>May 26</b> , 19 <b>59</b> , to <b>Sept. 15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 13</b> , 19 <b>59</b> , and that death occurred at <b>12:25A</b> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>		DATE SIGNED <b>9-15-59</b>		26. I certify that I attended the deceased from <b>May 26</b> , 19 <b>59</b> , to <b>Sept. 15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 13</b> , 19 <b>59</b> , and that death occurred at <b>12:25A</b> , from the causes and on the date stated above			

Montgomery Co., Deputy Medical Examiner notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit from the certificate and return it to the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

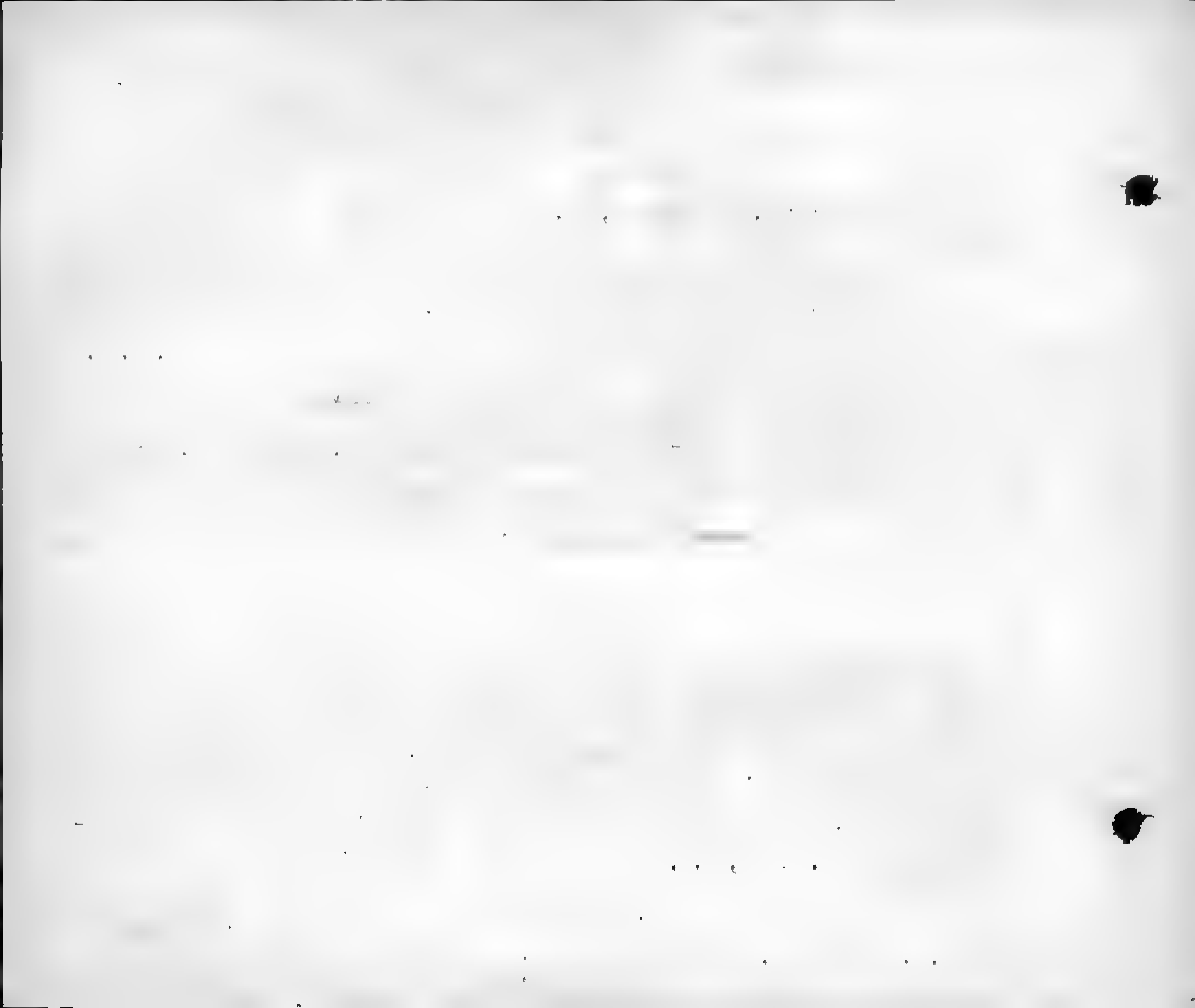
Item 18 Film 262, 5/9/60-AMS)

10480

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Alabama</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Birmingham</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>42 Edgehill Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Ray</b> Middle <b>Clarence</b> Last <b>Mork</b>				4. DATE OF DEATH Month <b>September</b> Day <b>1</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 8, 1900</b>	
9. AGE (In years last birthday) <b>59</b> yrs		IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>59</b> Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Administrator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical Journal</b>	
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13. FATHER'S NAME <b>Reuben Mork</b>		14. MOTHER'S MAIDEN NAME <b>Clara Kittelson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or date of service) <b>WW I</b>		16. SOCIAL SECURITY NO <b>577-42-9978</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Congestive heart failure</b> DUE TO <b>Latent Heart Disease with Aortic Insufficiency of</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>unknown origin</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>15 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>August 25, 19 59</b> , to <b>September 1, 19 59</b> , that I last saw the deceased alive on <b>September 1, 19 59</b> , and that death occurred at <b>10:15 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>9-2-59</b> ACTUAL SIGNATURE <b>Victor W. Sidel</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Victor W. Sidel, M.D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. Arlington, Virginia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St., N.W.</b> <b>Washington 9, D.C.</b>				24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



## CERTIFICATE OF DEATH

10450

Reg. Dist. No.

10481

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>	
c. LENGTH OF STAY IN b. <b>16 hours</b>		d. STREET ADDRESS <b>108 King William Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nellie Frances Motley</b>		4. DATE OF DEATH Month Day Year <b>9 5 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3.28.1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Denis O'Neill</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Downing</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inanition</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Arthritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>5 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1958</b> 19 <b>Sept 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 4</b> , 19 <b>57</b> , and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>9/5/57</b>			
ACTUAL SIGNATURE <b>Richard A. Yates MD</b>		PHYSICIAN'S NAME (Type) <b>Richard A. Yates, M. D.</b> <b>Olney, Maryland</b> <b>9.5.59</b>	
22a. RITUAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>9-8-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cate of St. Ann's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Olney, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas H. Hannon</b>		ADDRESS <b>3831 Ga Ave NW</b>	
24. REC'D BY REGISTRAR <b>SEP 18 59</b>		25. REGISTRAR'S SIGNATURE <b>Arthur J. Hannon</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



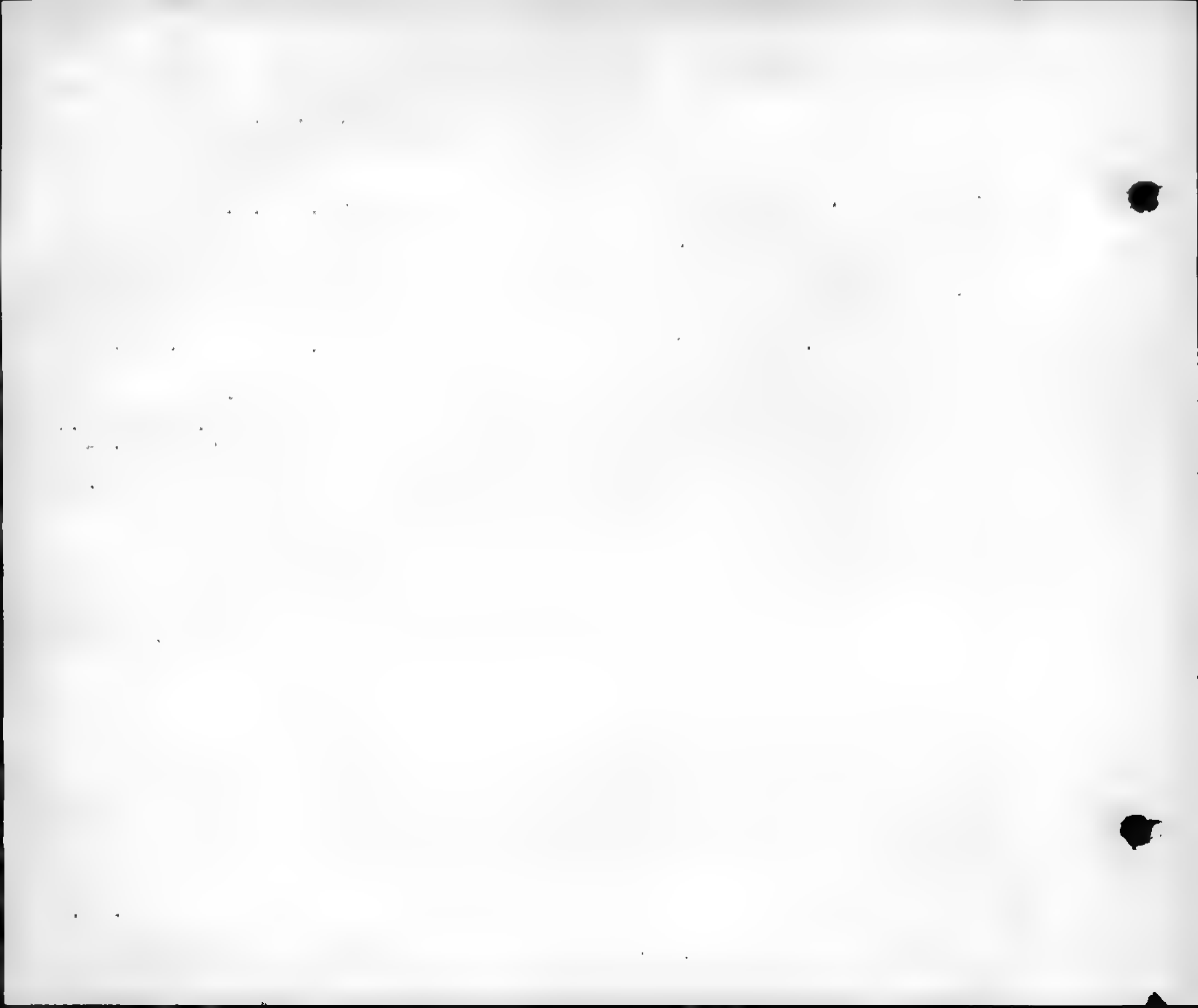
10362

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY <b>47</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Eventide Nursing Home</b>		d. STREET ADDRESS <b>1750 Harvard St., N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARIA</b> Middle <b>T</b> Last <b>MORSE</b>		4. DATE OF DEATH Month <b>9</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-27-1883</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physicist at Bureau of Standards</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>of Standards</b>	
11. BIRTHPLACE (State or foreign country) <b>Brooklyn, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Henry Morse</b>		14. MOTHER'S MAIDEN NAME <b>Louise Parish Townsend</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Florence Greble</b>		Address <b>355 E. 68th St., New York, N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4 72 x</b> DUE TO <b>Presumed acute organic heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <b>Arteriosclerotic, marked, and</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1940</b> to <b>9/24/1959</b> that I last saw the deceased alive on <b>9/24/1959</b> and that death occurred at <b>1:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>760 Carroll Ave. 9/25/59</b> DATE SIGNED <b>Chas H Wolohan</b> M.D. <b>Takoma Park Md.</b>			
ACTUAL SIGNATURE <b>Chas H Wolohan</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Chas H Wolohan</b>		<b>Takoma Park Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Removal</b>	22b. DATE THEREOF <b>19-28-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>BROOKLYN N. Y.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Sawlars Sons, Wash. D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kane</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G-51-1-59 et

10452

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>3 MOS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CONGRESSIONAL MAJOR HOME</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRINGS</b>	
3. NAME OF DECEASED (Type or print) First <b>SIMON</b> Middle <b>—</b> Last <b>MOSER</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>20</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 10 1896</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herman</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>DR L. M. MOSER</b>		Address <b>BETHESDA, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO <b>ARTERIO SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PARKINSON'S DISEASE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUGUST</b> , 19 <b>54</b> , to <b>SEPT.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>SEPT. 19</b> , 19 <b>59</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Kenneth M Moser</b>		ADDRESS (Street, city or town, state) <b>9420 Bulls Run Pkwy BETH. -14, MD</b>	
DATE SIGNED <b>9/20/59</b>			
PHYSICIAN'S NAME (Type) <b>—</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ober Shalom</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc</b>		ADDRESS <b>2100 Eutaw Pl</b>	
24a. REC'D BY REGISTRAR <b>SEP 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>—</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10453

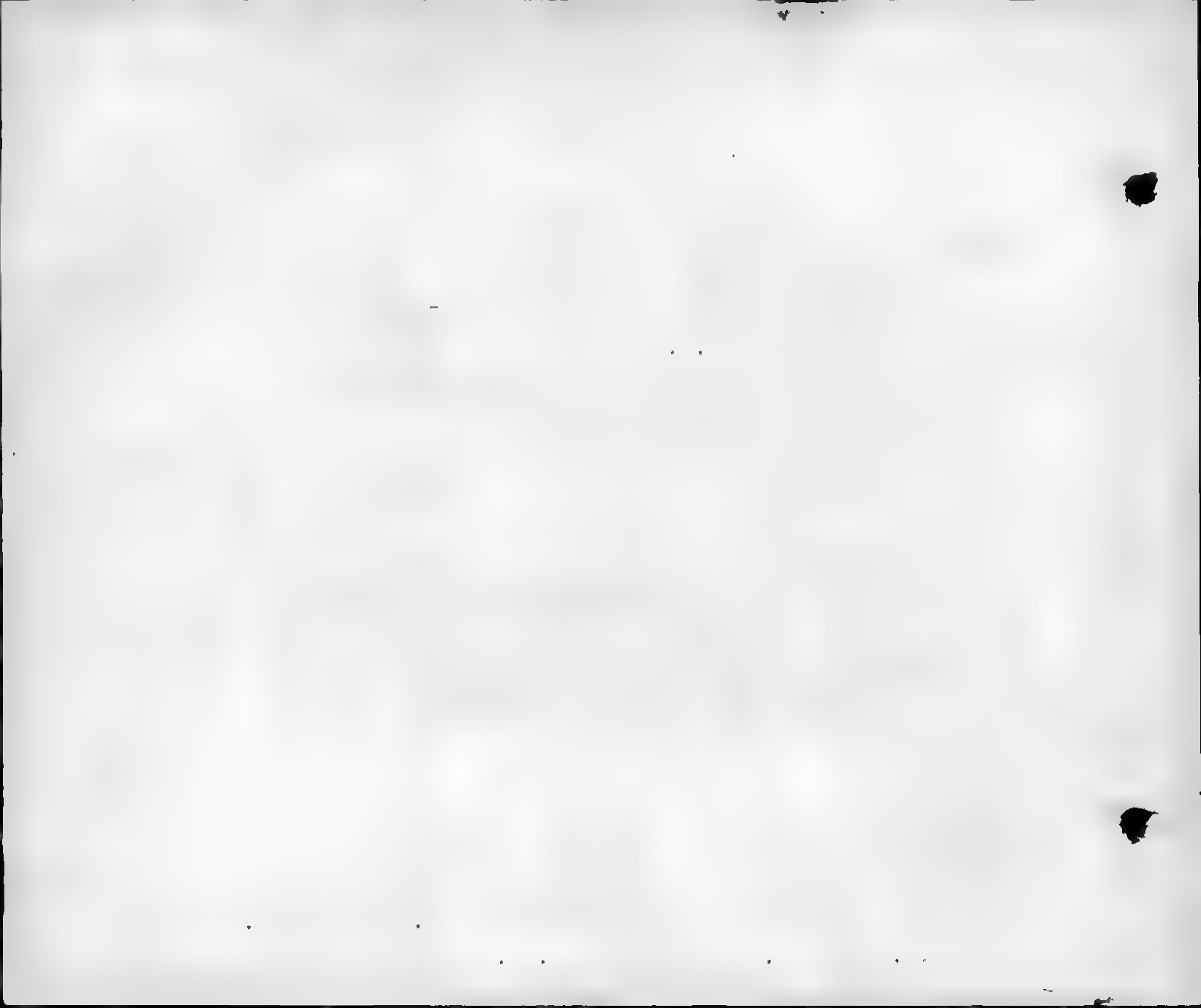
10363

Item 22 Film G249 9/22/59 JWS

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>9 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. Rainier</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>4004 24th ST</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Murray</u>				4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-29-1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disabled soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Murray</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Miss Mary Johnson 4004 24th St Mt. Rainier Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Enter Chronic Renal Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall down stairs at home</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>12:30</u> a. m. <u>4-16</u> p. m. <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Mt Rainier - P.G. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-17-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md. Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co. Washington, D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

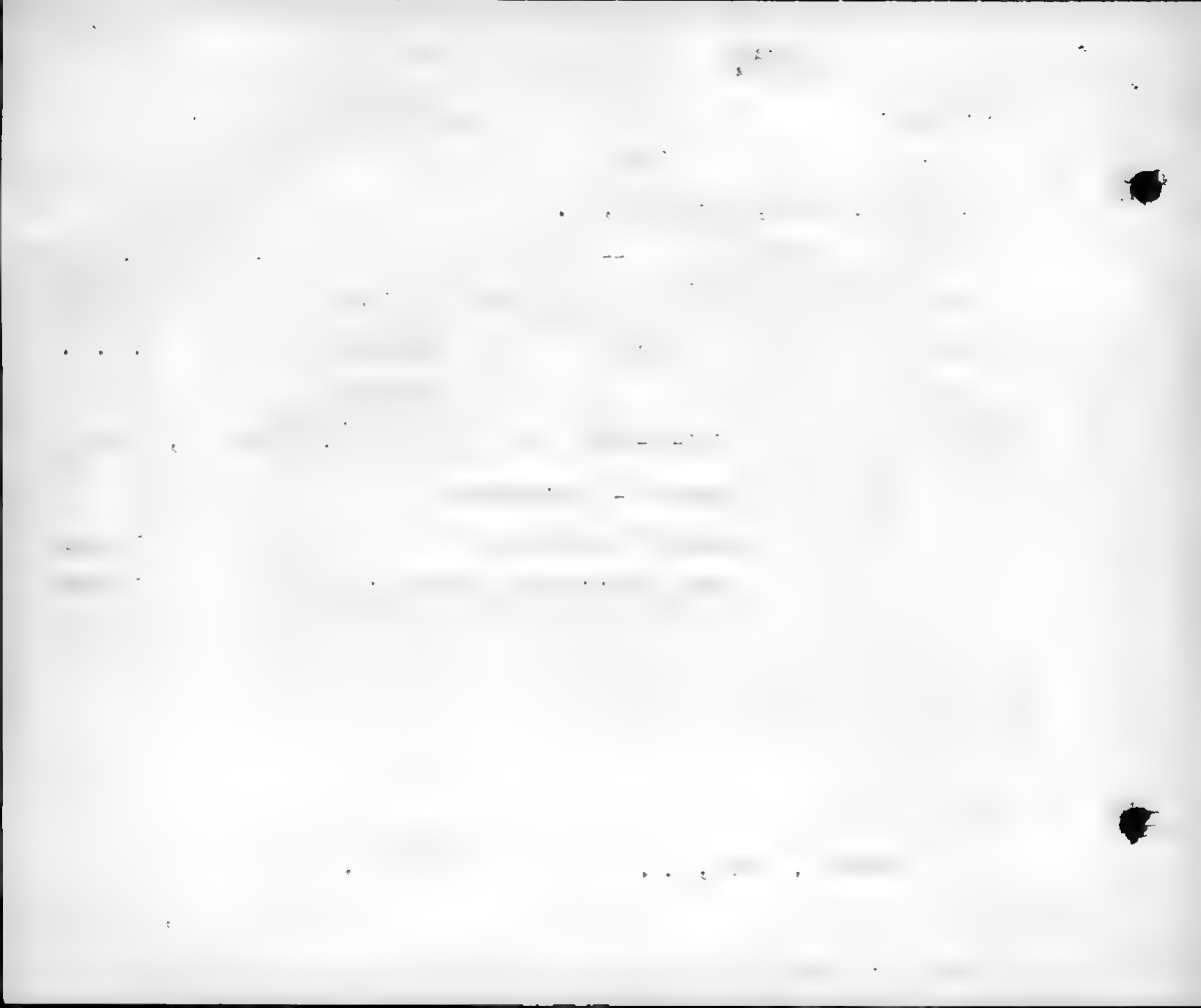
10483

CERTIFICATE OF DEATH

Reg. Dist. No.

10454

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Tennessee</b> b. COUNTY <b>Campbell</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaFollette</b> <b>794</b>			
3. NAME OF DECEASED (Type or print) First <b>Lorene</b> Middle <b>--</b> Last <b>Myers</b>				4. DATE OF DEATH Month <b>September</b> Day <b>15</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 16, 1928</b>	
9. AGE (In years last birthday) <b>30 yrs.</b>		10. IF UNDER 1 YEAR Months <b>30</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Dock Adkins</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Goad</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>193-20-7098</b>			
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Operative - Cardiac Arrest</b>							
DUE TO <b>410X</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>Rheumatic Heart Disease</b>							
DUE TO							
(c) <b>Mitral Insufficiency and Stenosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>a. m.</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August 30, 1959</b> to <b>September 15, 1959</b> , that I last saw the deceased alive on <b>September 15, 1959</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above							
ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>September 15, 1959</b>							
ACTUAL SIGNATURE <b>Kenneth O. Carney, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Kenneth O. Carney, M.D.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9/20/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Sharp Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Campbell County, Tennessee</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>			
24a. REC'D BY REGISTRAR <b>DATE SEP 17 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>			



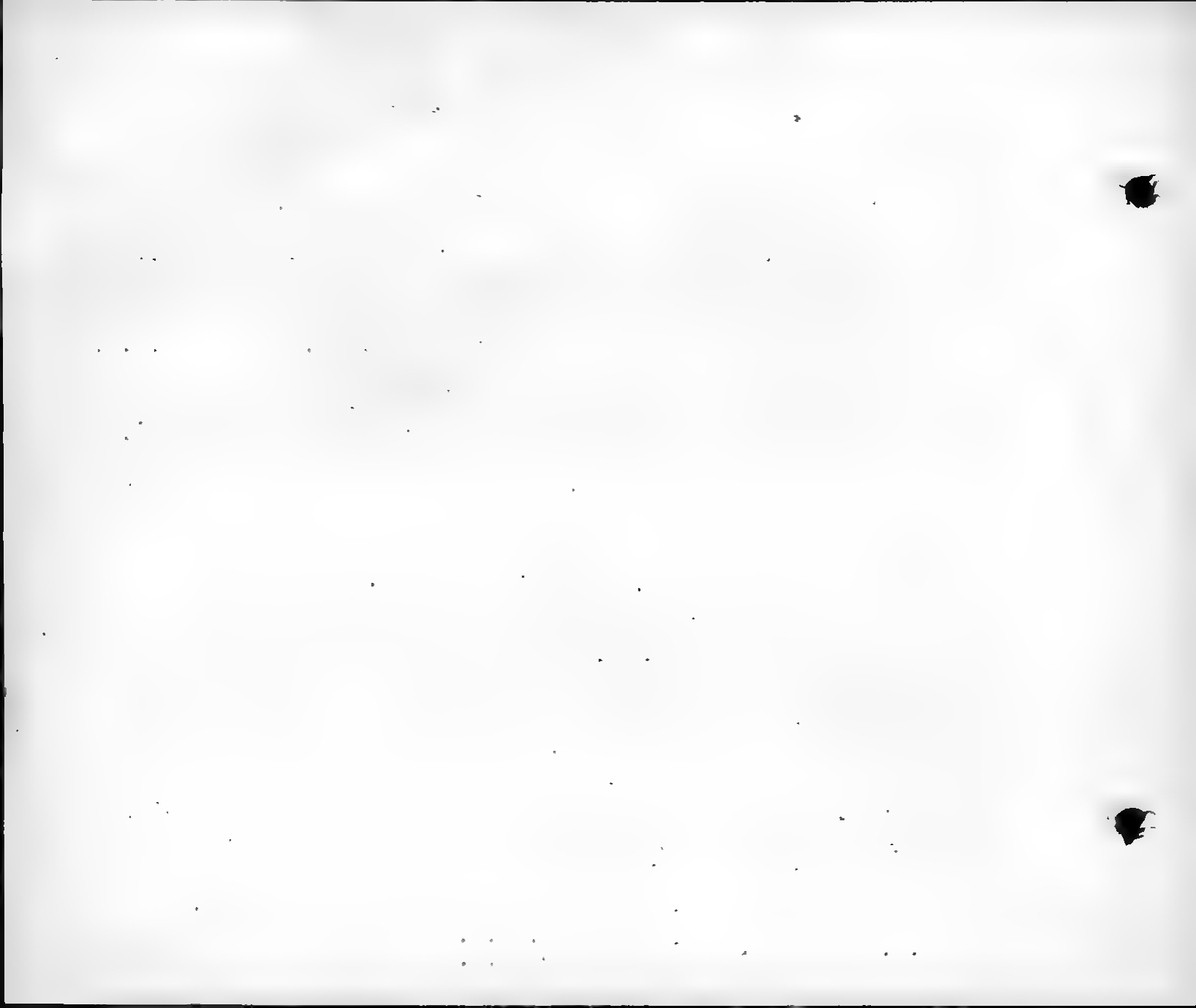
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10484**  
**CERTIFICATE OF DEATH**

10455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>427 Pershing Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lillian Mary O'Neil</b>				4. DATE OF DEATH Month Day Year <b>September 20, 1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/6/80</b>	9. AGE (In years from birthday) yrs <b>79</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Meister</b>				14. MOTHER'S MAIDEN NAME <b>Louise Muhlstein</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-26-0141</b>		INFORMANT <b>8807 Bradford Rd. Silver Spring, Md.</b> <b>Harry O'Neil</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>154X</b> DUE TO <b>Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Primary Adeno-Carcinoma of rectum</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>8 mo.</b> <b>10 mo.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year Hour a. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Dec 24, 1954</b> to <b>Sept 20, 1959</b> , that I last saw the deceased alive on <b>Sept 19, 1959</b> , and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George L. Ball</b> (M.D.)				ADDRESS (Street, city or town, state) <b>10620 Georgia Ave. Silver Spring Md.</b>			
PHYSICIAN'S NAME (Type) <b>George L. Ball</b>				DATE SIGNED <b>Sept 20 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>9/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				24a. REC'D BY REGISTRAR <b>2901 14th St. N.W. Washington 9, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>SEP 22 '59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10456

Reg. Dist. No.

10485

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COPPERSBURG</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10,020 MENLO AVENUE</b>				d. STREET ADDRESS <b>ROUTE #2</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FILI</b>		First <b>PECHACEK</b>		Last		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/80</b>		9. AGE (in years last birthday) <b>79</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWNER OF HOTEL (RETIRED) HOTEL</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CZECHOSLOVAKIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOSEPH JASEK</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT Address <b>Miss Angela Pechacek, Route #2 Coppersburg, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>9/26/59</b>	
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>9/30/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CALVARY EMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>LIMEPOST, PENNSYLVANIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i>		ADDRESS <b>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>SEP 28 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

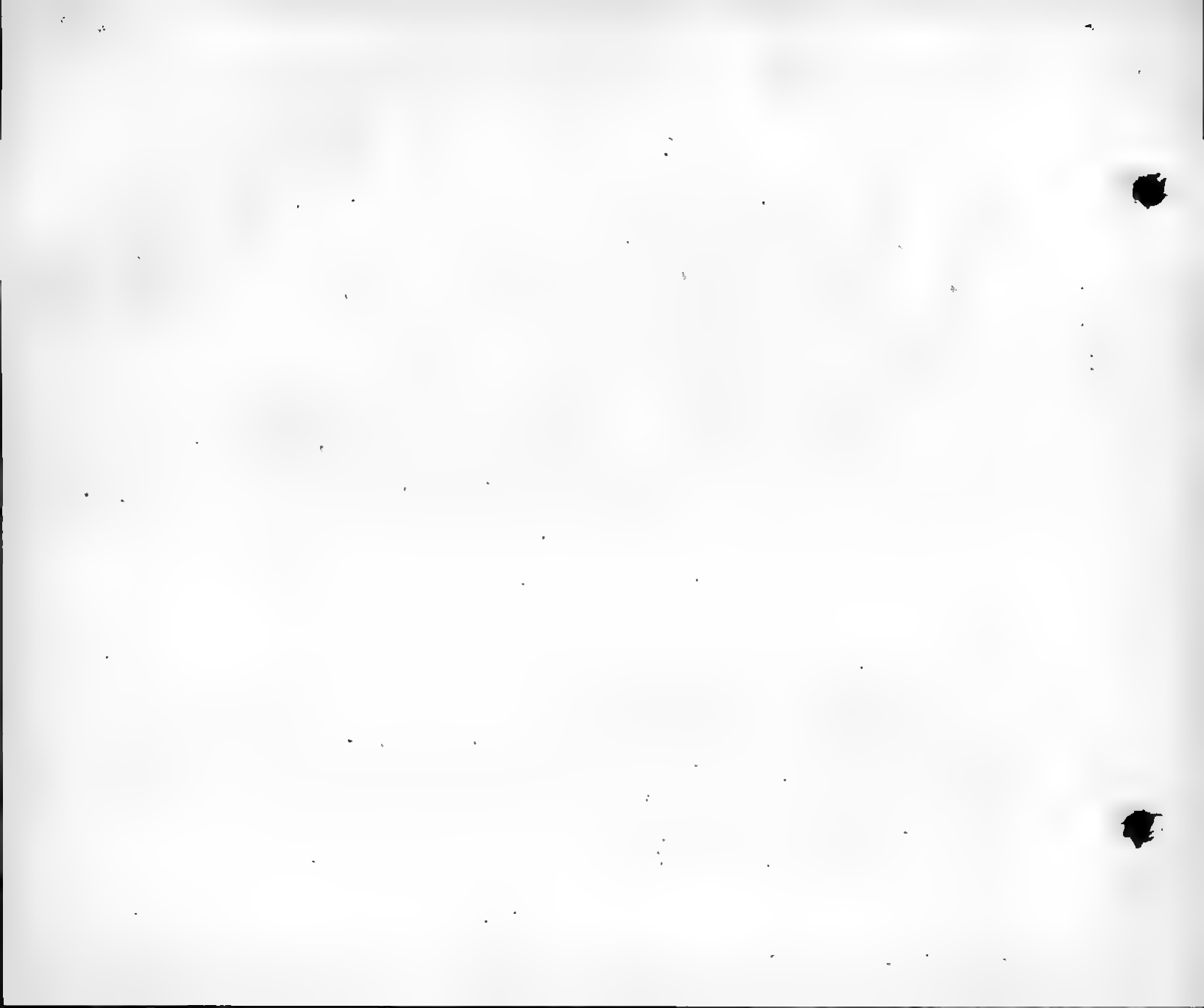
## CERTIFICATE OF DEATH

Reg. Dist. No.

10486

10457

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>5 WEEKS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Resh Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>ANNA</b> First <b>E</b> Middle <b>Peebles</b> Last		4. DATE OF DEATH Month <b>9</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 7, 1889</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR: Months <b>5</b> Days <b>25</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Ibels</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Roelker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Leighton H Peebles, Husband-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Cerebral cortical atrophy, severe</b> <b>Cerebral arteriosclerosis, severe</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>5 yrs +</b> <b>5 yrs +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1959</b> to <b>Sept 2, 1959</b> , that I last saw the deceased alive on <b>Aug 31, 1959</b> , and that death occurred at <b>6:10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stewart Clapp</b>		DATE SIGNED <b>9-2-59</b>	
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>		ADDRESS (Street, city or town, state) <b>3921 Ingomar St. Wash 15 D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>9/8/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>SEP 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kears</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

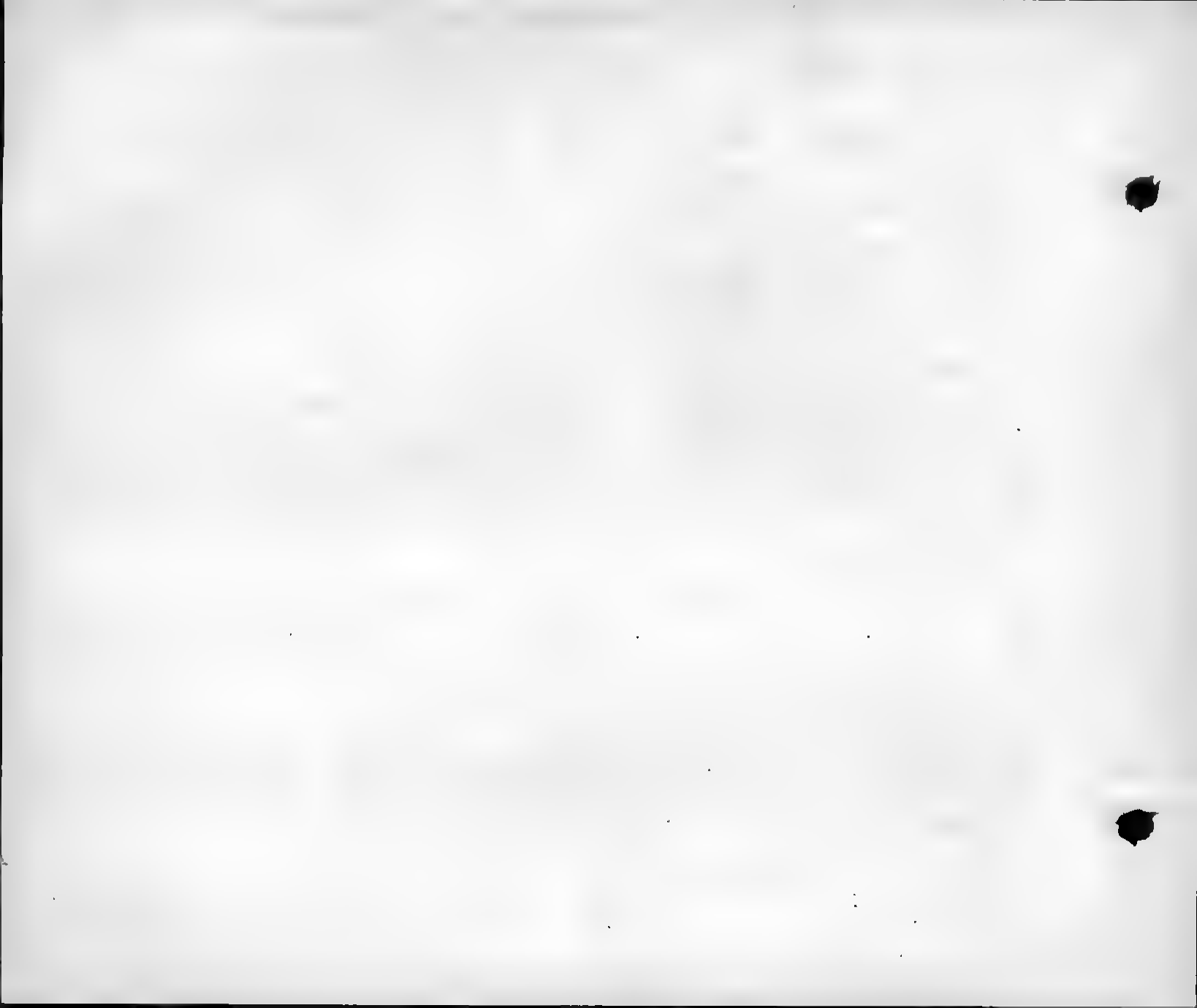
10458

10487

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>9 1/2 mo.</u>				d. STREET ADDRESS <u>10215 Woodmoor Circle</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Oakley</u> Last <u>Penn</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 30-1882</u>	
9. AGE (In years last birthday) <u>76 yrs</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>17</u> Min <u>17</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (State or foreign country) <u>Towson, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Joseph Peregrino</u>				14. MOTHER'S MAIDEN NAME <u>Louise Oakley</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hosp. records</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hematuria - Undetermined Cause</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-3-</u> , 19 <u>59</u> , to <u>9-19-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-14-</u> , 19 <u>59</u> , and that death occurred at <u>30</u> P.M., from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Roy B. Parsons Jr.</u>				ADDRESS (Street, city or town, state) <u>Burtonsville Md</u> DATE SIGNED <u>9-12-59</u>			
PHYSICIAN'S NAME (Type) <u>Roy B. Parsons Jr.</u>				M.D. <u>—</u>			
22a. BURIAL, CREMATION, OR DISPOSAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 21-1959</u>		<u>St. Mary's (Hampden)</u>		<u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u> ADDRESS <u>3631 Falls Road</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur A. Fink</u>							



10364

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>506 TULIP AVE</b>				d. STREET ADDRESS <b>1 506 TULIP AVE</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JACOB FRANKLIN PESTER</b>				4. DATE OF DEATH Month Day Year <b>SEPT 4 1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11-1870</b>	9. AGE (In years last birthday) <b>89 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>White Plains, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mr. Harry Pester</b>				14. MOTHER'S MAIDEN NAME <b>Eleanor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <b>Mr. Earl A. Pester</b> Address <b>506 Tulip Ave Takoma Park</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>Branchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Suppurative pneumonia &amp; malnutrition</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1951</b> to <b>Sept 4, 1959</b> , that I last saw the deceased alive on <b>Sept 3, 1959</b> , and that death occurred at <b>1100 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Russell B. Arnold</b> M.D. <b>8801 Cokesville Ave.</b>				DATE SIGNED <b>1/4/59</b>			
PHYSICIAN'S NAME (Type) <b>Russell B. Arnold M.D. Silver Spring, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Sept. 8, 1959</b>		<b>George Washington Cemetery</b>		<b>Prince Georges Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters, 254 Carroll St NW</b>				24a. DIED BY REGISTRAR DATE <b>SEP 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[Faint handwritten notes at the bottom of the page]*



10488

CERTIFICATE OF DEATH

Reg. Dist. No.

10460

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>426 E. Diamond Ave.</b>		d. STREET ADDRESS <b>426 E. Diamond Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Dorsey</b> Middle <b>C.</b> Last <b>Plummer</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>9</b> Year <b>1959</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1896</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N.I.H.</b>	
11. BIRTHPLACE (State or foreign country) <b>Montg. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Marvin E. Plummer</b>		14. MOTHER'S MAIDEN NAME <b>Alice Clagett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.1 218-05-0220</b>	
17. INFORMANT <b>Mrs Rena Plummer, Gaithersburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Dissecting Aneurysm of Abdominal Aorta</b> DUE TO <b>45ix</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO <b>15 YEARS</b> (c) <b>Generalized Arteriosclerosis</b> DUE TO <b>15 YEARS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>KN HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA OF BLADDER</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 1957</b> to <b>September 9, 1959</b> that I last saw the deceased alive on <b>September 9, 1959</b> and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John H. Rosenberg</b> M.D.		ADDRESS (Street, city or town, state) <b>26 N. Summit Ave Gaithersburg, Md.</b>	
DATE SIGNED <b>Sept 9, 1959</b>			
PHYSICIAN'S NAME (Type) <b>Gaithersburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 12, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John L. Moleworth</b>		ADDRESS <b>Damascus, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AL Aorta

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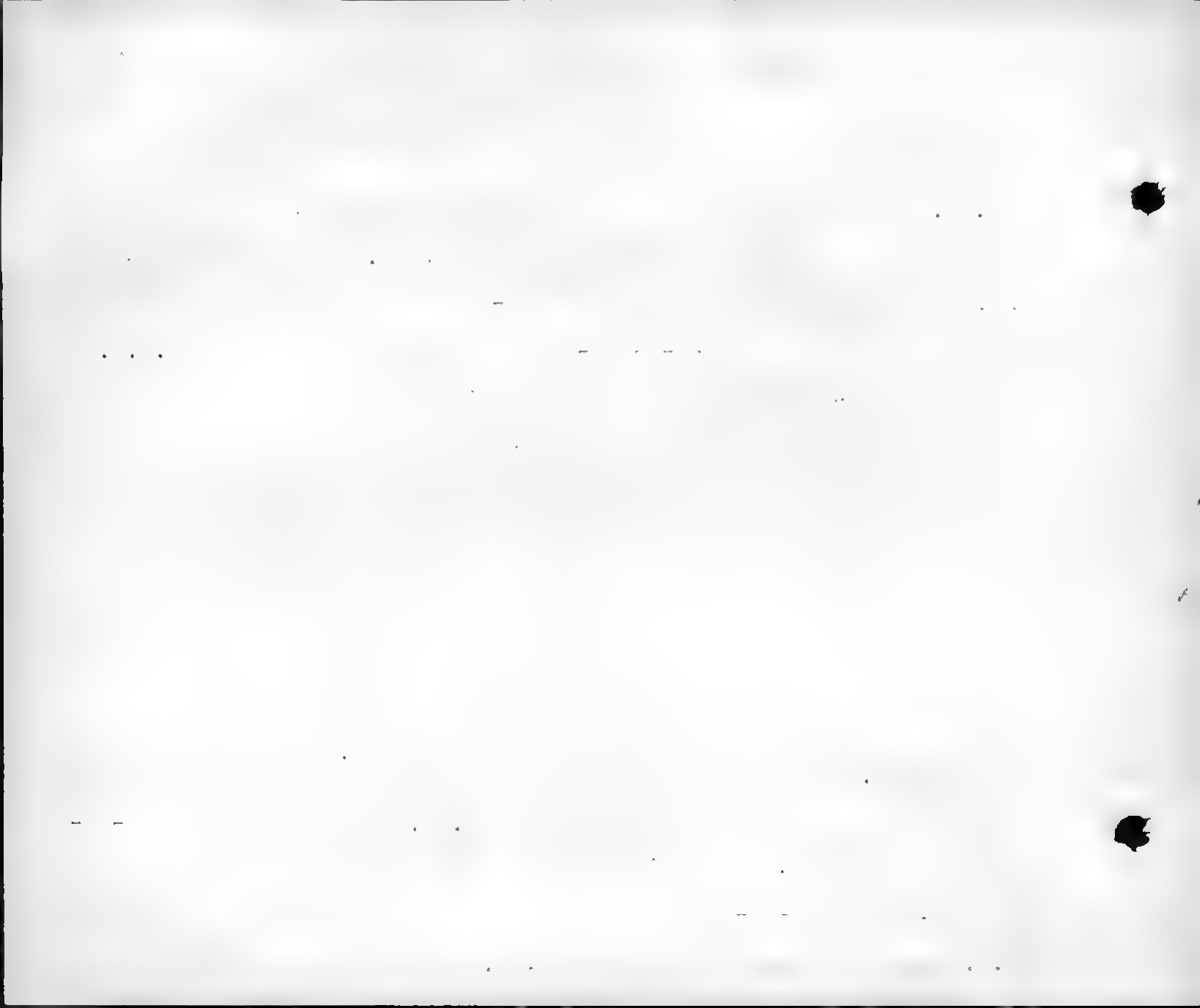
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <b>New Hampshire</b> c. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>21 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>South Main Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Conrad</b> Last <b>POELMAN, JR.</b>				4. DATE OF DEATH Month <b>September</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-8-54</b>	
9. AGE (In years last birthday) <b>5</b> yrs		IF UNDER 1 YEAR Months <b>5</b> Days <b>16</b> Hours <b>19</b> Min <b>59</b>		IF UNDER 24 HRS. Months <b>5</b> Days <b>16</b> Hours <b>19</b> Min <b>59</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Ralph Conrad POELMAN</b>				14. MOTHER'S MAIDEN NAME <b>Novella SHARPE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Heart Disease</b> DUE TO <b>(Post operative state) Aortic Stenosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August 26, 1959</b> to <b>Sept. 16, 1959</b> , that I last saw the deceased alive on <b>Sept. 16, 1959</b> , and that death occurred at <b>940 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>9-17-59</b>							
ACTUAL SIGNATURE <b>Douglas R. Koth</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Douglas R. KOTH, LCDR, MC, USN</b>				Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>				22b. DATE THEREOF <b>9-17-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Funeral Home</b>				22d. LOCATION (City, town, or county) (State) <b>Wolfeboro New Hampshire</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				24a. REC'D BY REGISTRAR <b>SEP 21 '59</b>			
ADDRESS <b>Funeral Home, Bethesda, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10490

Reg. Dist. No. 215

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN TB <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US NAVAL HOSP. NMMC</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>1030 N. Randolph</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Richard PROBST</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>20</b> Year <b>1959</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cau.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 Aug. 1959</b>
9 AGE (in years last birthday) <b>22</b> yrs		10. IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Donald Martin PROBST</b>		14. MOTHER'S MAIDEN NAME <b>Janet G.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17 INFORMANT <b>Mrs. Janet G. PROBST (Mother)</b>		Address <b>(Mother)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pneumonitis, bilateral</b> <b>763.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. BROSCART</b>		DATE SIGNED <b>9-21-59</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-24-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chestnut Level Presbyterian Church Lancaster, Penn.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b> ADDRESS <b>7557 Wisconsin Ave. Bethesda Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 23 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



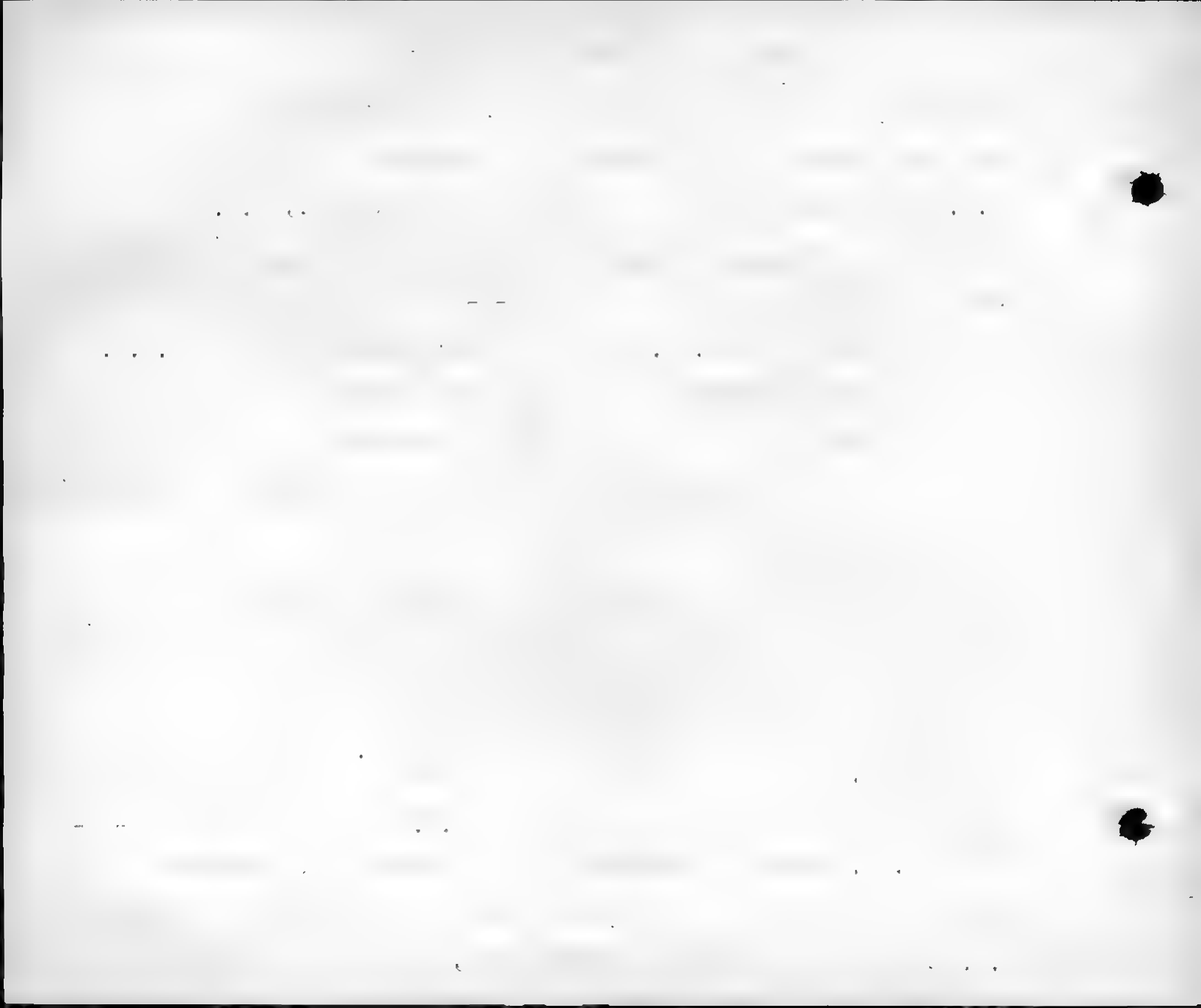
10491

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>42 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				2 USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before adm. ss an) a. STATE <b>District of Columbia</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>3730 Fordham Rd., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Neely</b> Last <b>RAINES</b> 4. DATE OF DEATH Month <b>September</b> Day <b>16</b> Year <b>1959</b>				5. SEX <b>Male</b> 6. COLOR OR RACE <b>Caucasian</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>4-2-08</b> 9. AGE (In years, last birthday) <b>51</b> yrs. IF UNDER 1 YEAR: Months <b>1</b> Days <b>16</b> IF UNDER 24 HRS: Hours <b>16</b> Min <b>16</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Officer</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b> 11. BIRTHPLACE (State or foreign country) <b>Mississippi</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>William Giles RAINES</b> 14. MOTHER'S MAIDEN NAME <b>Bessie HOSKINS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>1930 to 1959</b> INFORMANT <b>Hospital Records</b> Address				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma with diffuse metastases</b> 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastases</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>18 mos (approx)</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. <b>1</b> p. m. <b>1</b> 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <b>August 5, 1959</b> to <b>Sept. 16, 1959</b> , that I last saw the deceased alive on <b>Sept. 15, 1959</b> and that death occurred at <b>430AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital</b> DATE SIGNED <b>9-16-59</b> ACTUAL SIGNATURE <b>G. I. Walker</b> M.D. <b>G. I. Walker, CAPT, MC, USN</b> <b>Bethesda 14, Maryland</b> PHYSICIAN'S NAME (Type) <b>G. I. WALKER, CAPT, MC, USN</b> <b>Bethesda 14, Maryland</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>9-18-59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b> 22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b> ADDRESS <b>Funeral Home, Bethesda, Md.</b> 24a. REC'D BY REGISTRAR <b>SEP 18 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

MEDICAL CERTIFICATION





10492

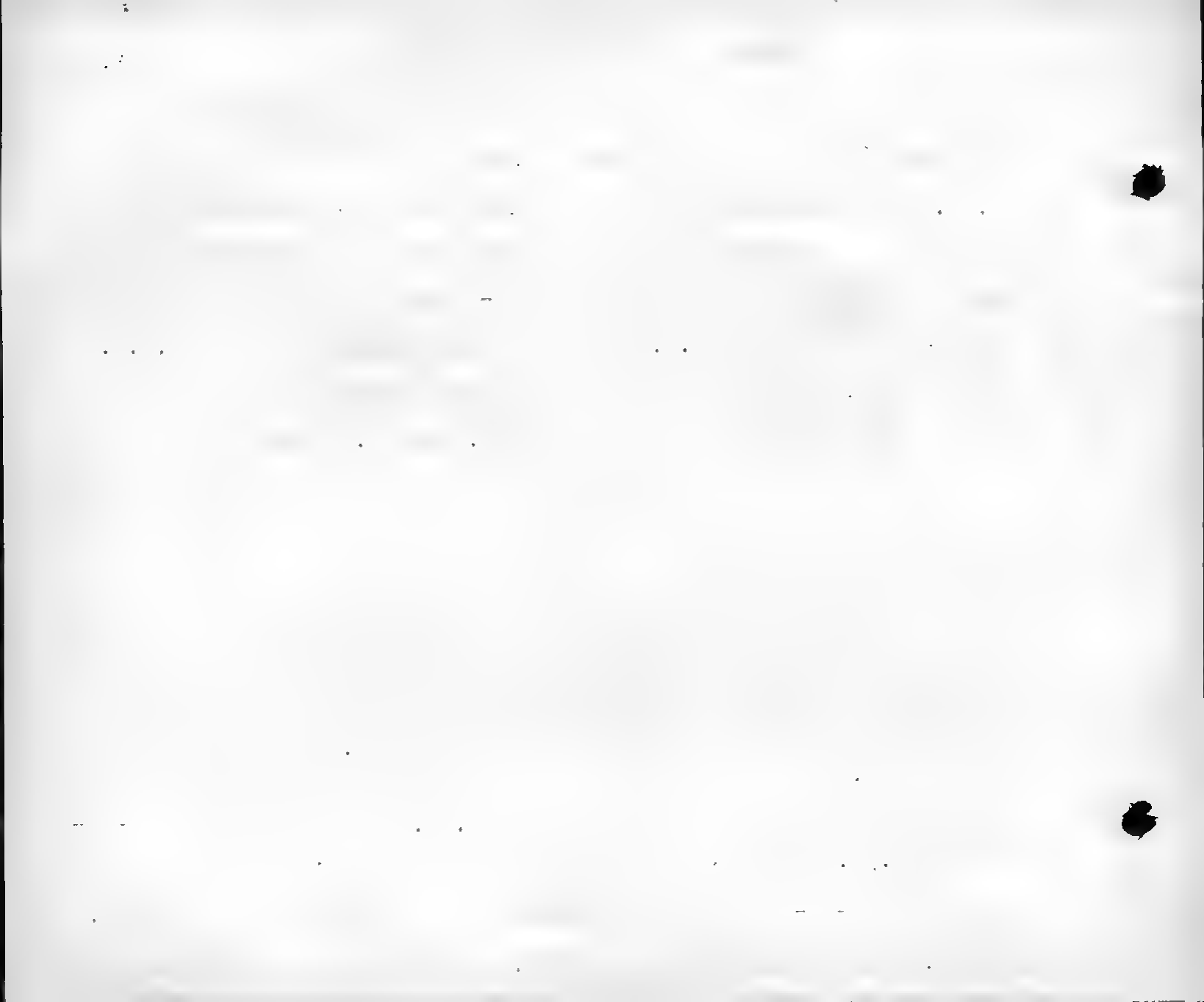
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>68 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, give name of institution) a. STATE <b>Maryland</b> b. COUNTY <b>Ann Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>1202 President Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Perry RASMUSSEN</b>				4. DATE OF DEATH Month Day Year <b>September 13 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-23-99</b>	
9. AGE (In years last birthday) <b>59</b>		F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Rasmussen</b>				14. MOTHER'S MAIDEN NAME <b>Martha Griswold</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>WWI &amp; II</b>		INFORMANT <b>(W) Mrs. Mary A. Rasmussen, same as #2</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiogenic Carcinoma - metastatic</b> <b>162.1</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>15 mos.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 7, 1959</b> to <b>Sept. 13, 1959</b> that I last saw the deceased alive on <b>Sept. 12, 1959</b> and that death occurred at <b>1:45 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>9-14-59</b>							
ACTUAL SIGNATURE <b>B. C. Johnson</b>		M.D. <b>U. S. Naval Hospital</b>					
PHYSICIAN'S NAME (Type) <b>B. C. Johnson, LCDR, MC, USN</b>		<b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-16-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Naval Academy</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Son, Annapolis, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur G. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1810465

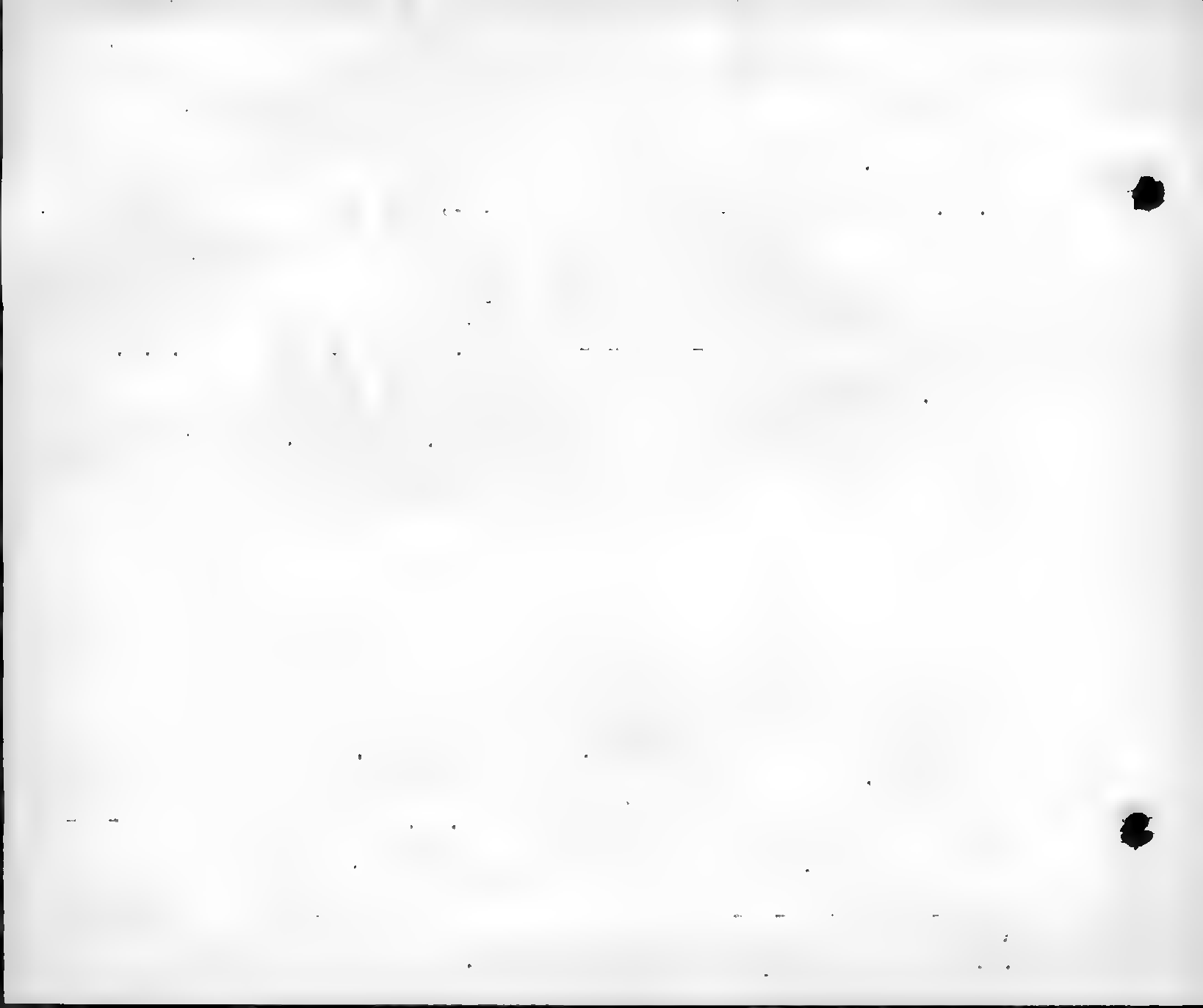
10494

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alleghany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Covington</b> d. STREET ADDRESS <b>Rt. 6, Box 192</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Regina</b> Middle <b>REYNOLDS</b> Last <b>REYNOLDS</b>		4. DATE OF DEATH Month <b>September</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-22-59</b>
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>No. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leo D. REYNOLDS</b>		14. MOTHER'S MAIDEN NAME <b>Willadean STURGILL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>(F) Leo D. Reynolds, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congenital heart disease.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 9, 1959</b> to <b>Sept. 17, 1959</b> , that I last saw the deceased alive on <b>Sept. 17, 1959</b> , and that death occurred at <b>2:26 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital 9-17-59</b>			
ACTUAL SIGNATURE <b>Harry L. Walton</b> M.D.		U. S. Naval Hospital 9-17-59	
PHYSICIAN'S NAME (Type) <b>Harry L. WALTON, LT, MC, USN Bethesda, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 9-18-59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>R.A. Pumphrey Funeral Home, Bethesda, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Covington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>SEP 21 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur A. ...</b>		DATE	

9000000000



## CERTIFICATE OF DEATH

Reg. Dist. No.

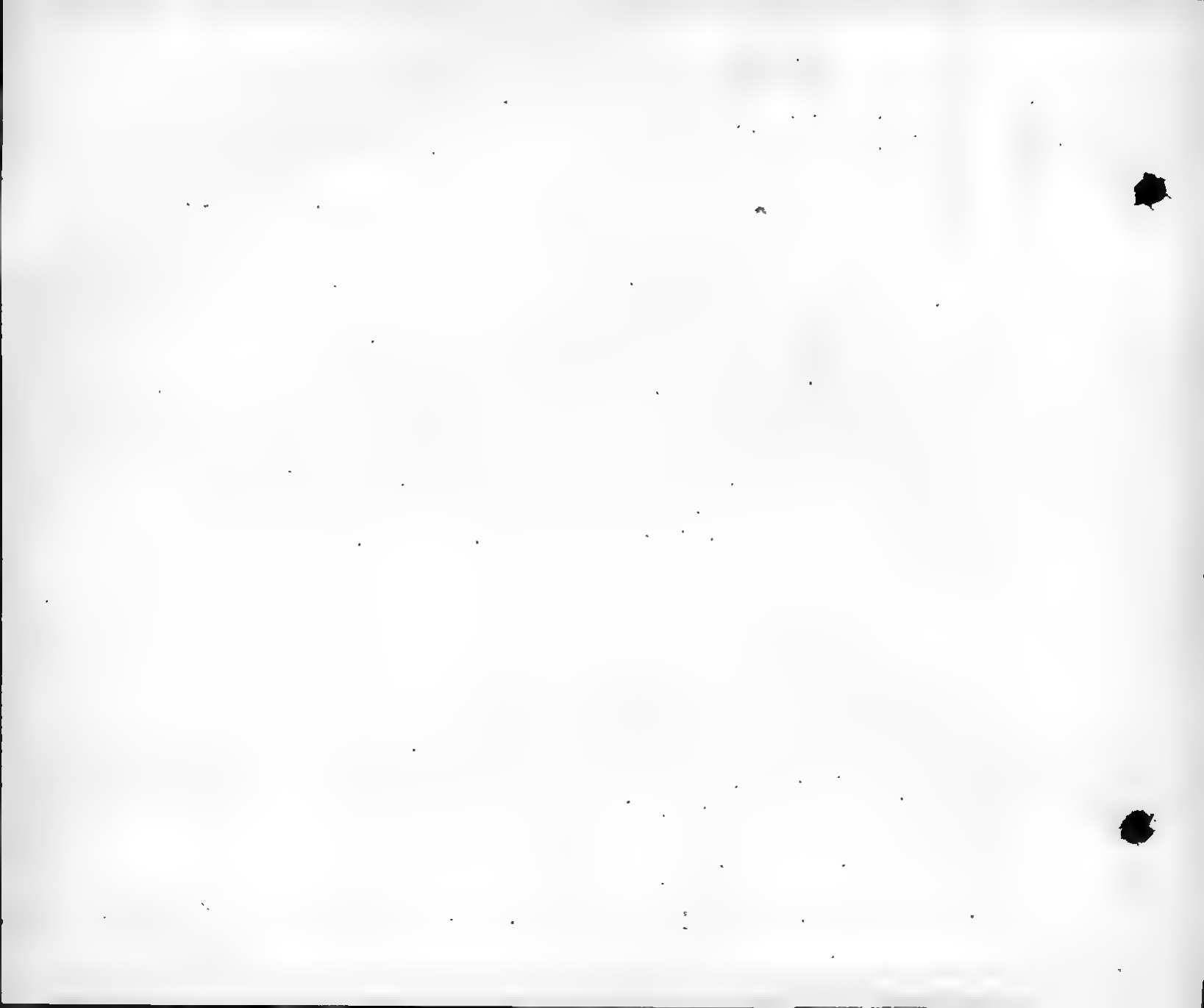
10495

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hr 7 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY BOY RIEDEL</u>		4. DATE OF DEATH <u>SEPTEMBER 2 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPTEMBER 2 1959</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR <u>1</u> Months <u>7</u> Days	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN THOMAS RIEDEL</u>		14. MOTHER'S MAIDEN NAME <u>AUDREY MAR STILES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature Twin 28 weeks</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>spont. premature labor</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/2</u> , 1959, to <u>9/2</u> , 1959, that I last saw the deceased alive on <u>9/2</u> , 1959, and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Albert S. Bright</u>		M.D. <u>—</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT S. BRIGHT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>9-3-59</u>	<u>Suburban Hosp.</u>	<u>Bethesda, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amel M. Cantory</u>		24. REC'D BY REGISTRAR <u>OCT 3 1959</u>	
ADDRESS <u>Sept -</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10496

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>1 hr - 15 min</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence after admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		e. STREET ADDRESS <b>3930 KINCAID TERRACE</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>BABY</b>		First <b>GIRL</b>		Middle <b>RIEDEL</b>		Last <b>RIEDEL</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b>		Day <b>2</b>		Year <b>1959</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPTEMBER 2 1959</b>		9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN THOMAS RIEDEL</b>		14. MOTHER'S MAIDEN NAME <b>AUDREY MAE STILES</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		INFORMANT <b>—</b>		Address <b>—</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>1. Premature Twin 28 weeks</b> <b>Spont. Premature Labor</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>9/2</b> , 19 <b>59</b> , to <b>9/2</b> , 19 <b>59</b> ; that I last saw the deceased alive on <b>9/2</b> , 19 <b>59</b> , and that death occurred at <b>7:30</b> A. M., from the causes and on the date stated above. <b>ADDRESS (Street, city or town, state)</b> <b>DATE SIGNED</b>													
ACTUAL SIGNATURE <b>Albert S. Bright</b>		M.D.											
PHYSICIAN'S NAME (Type) <b>ALBERT S. BRIGHT</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>9-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Suburban Hosp. Bethesda, Md.</b>		22d. LOCATION (City, town, or county)		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Armeda M. Carter</b>		ADDRESS <b>—</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>—</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/5/81

VS A15 (4)  
15M 9/58





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10468

Reg. Dist. No.

10497

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> - b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Arthur Nursing Home - 9301 Waverly St</u>				d. STREET ADDRESS <u>4223 Round Hill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E. K.</u> Last <u>Robey</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-18-896</u>	9. AGE (in years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant Chemist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Robey</u>				14. MOTHER'S MAIDEN NAME <u>Haisy Kelsner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Nursing Home Record</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause last. DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Boeschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BOESCHERT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-24-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



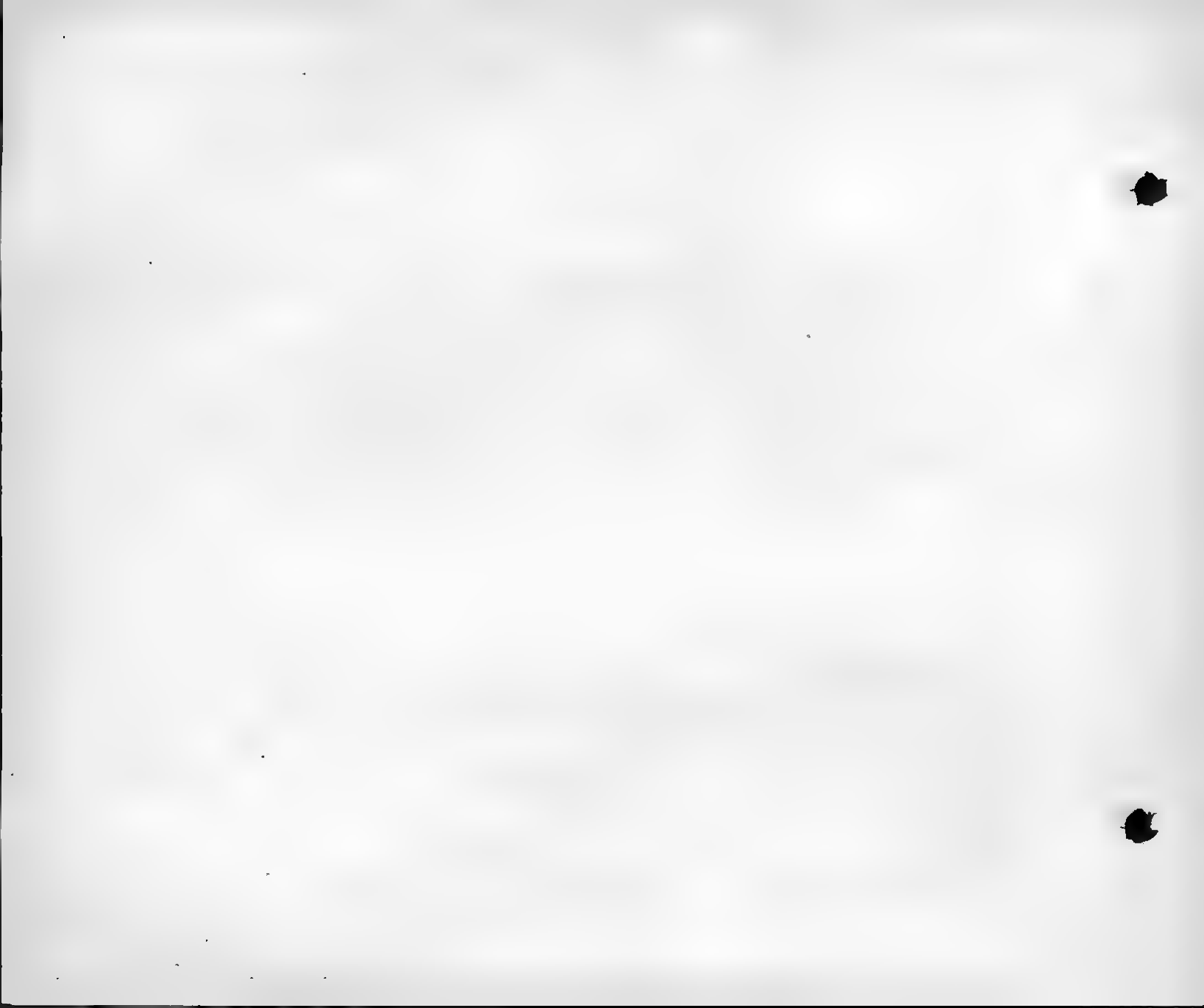
10498

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>S.</u> Last <u>Rayston</u>		4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 14 1882</u>
9. AGE in years (last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Clarke Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Riddle Rayston</u>		14. MOTHER'S MAIDEN NAME <u>Rhine V. Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>231-38-6162</u>	
17. INFORMANT <u>Mrs. Louise Reed, Burtonsville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerosis-hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 sec.</u> <u>1 sec.</u> <u>30 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 1955, to <u>Sept</u> , 1959, that I last saw the deceased alive on <u>Sept 20</u> , 1959, and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Frank L. Weaver Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>FRANK L. WEAVER JR.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/24/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Calver Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson, Laurel, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 25 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10499 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

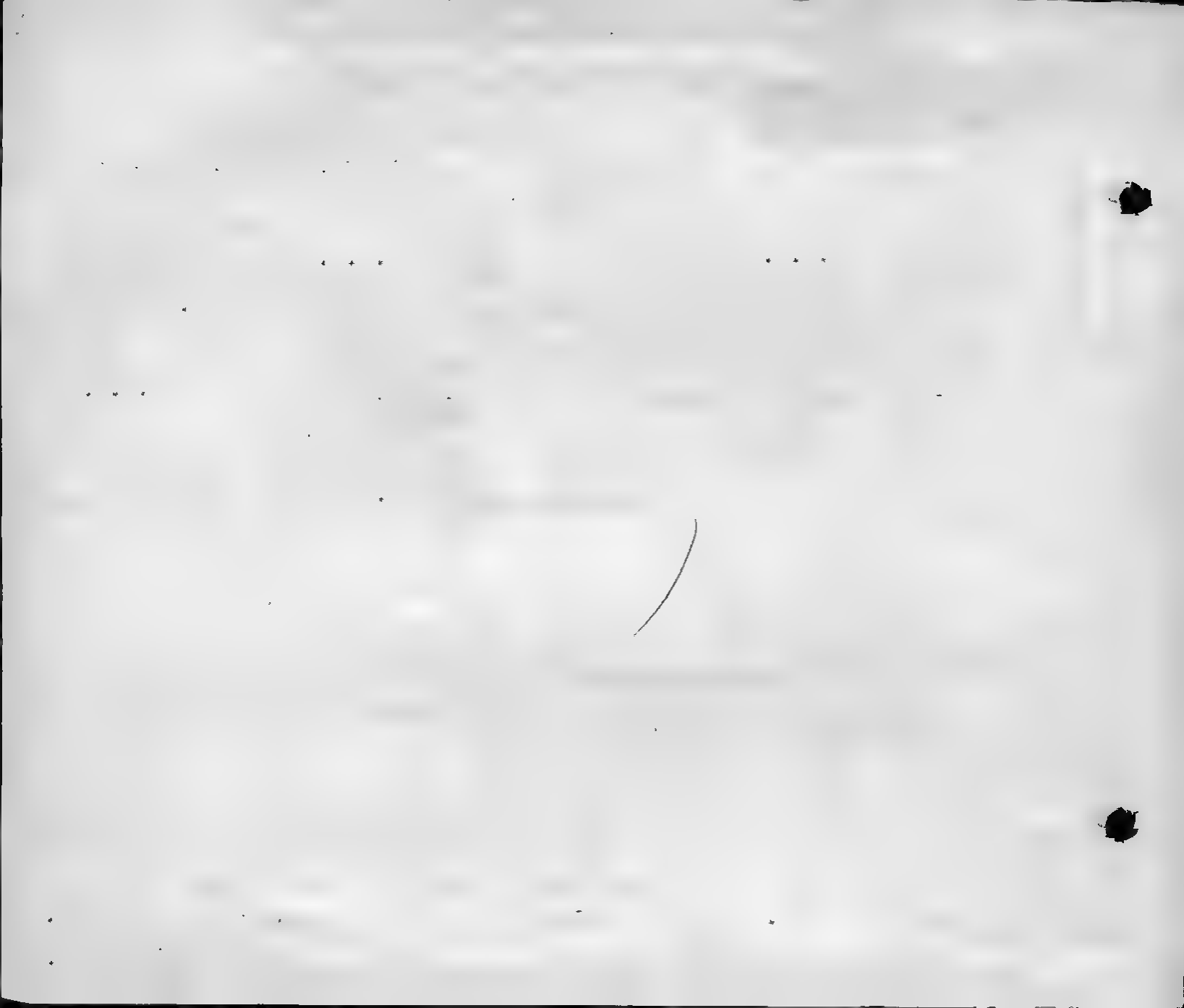
<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Derwood</u>		LENGTH OF STAY (in this place) <u>10 Years</u>		CITY OR TOWN <u>Derwood</u>		CITY OR TOWN <u>Derwood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. # 1</u>				STREET ADDRESS (If rural give location) <u>R.F.D. # 1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Edward Lee Runion</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept. 30 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 13 1894</u> 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if railroad) <u>Arm Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Runion</u>				14. MOTHER'S MAIDEN NAME <u>Anne Bixler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hazel B. Runion Same As 2</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Brochiectasis</u>				<u>10 + yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Sept. 23, 19 59</u> , to <u>Sept. 30, 19 59</u> , that I last saw the deceased alive on <u>Sept. 29, 19 59</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above. <u>9/30/59</u> SIGNATURE <u>James W. Egan M.D.</u> ADDRESS (Street, city, town, state) <u>7720 W. Mcconn Ave. Bethesda Md.</u> DATE SIGNED <u>9/30/59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 3 59</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur D. Kinn</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Royce Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	
DATE <u>OCT 2 '59</u>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10500**  
**CERTIFICATE OF DEATH**

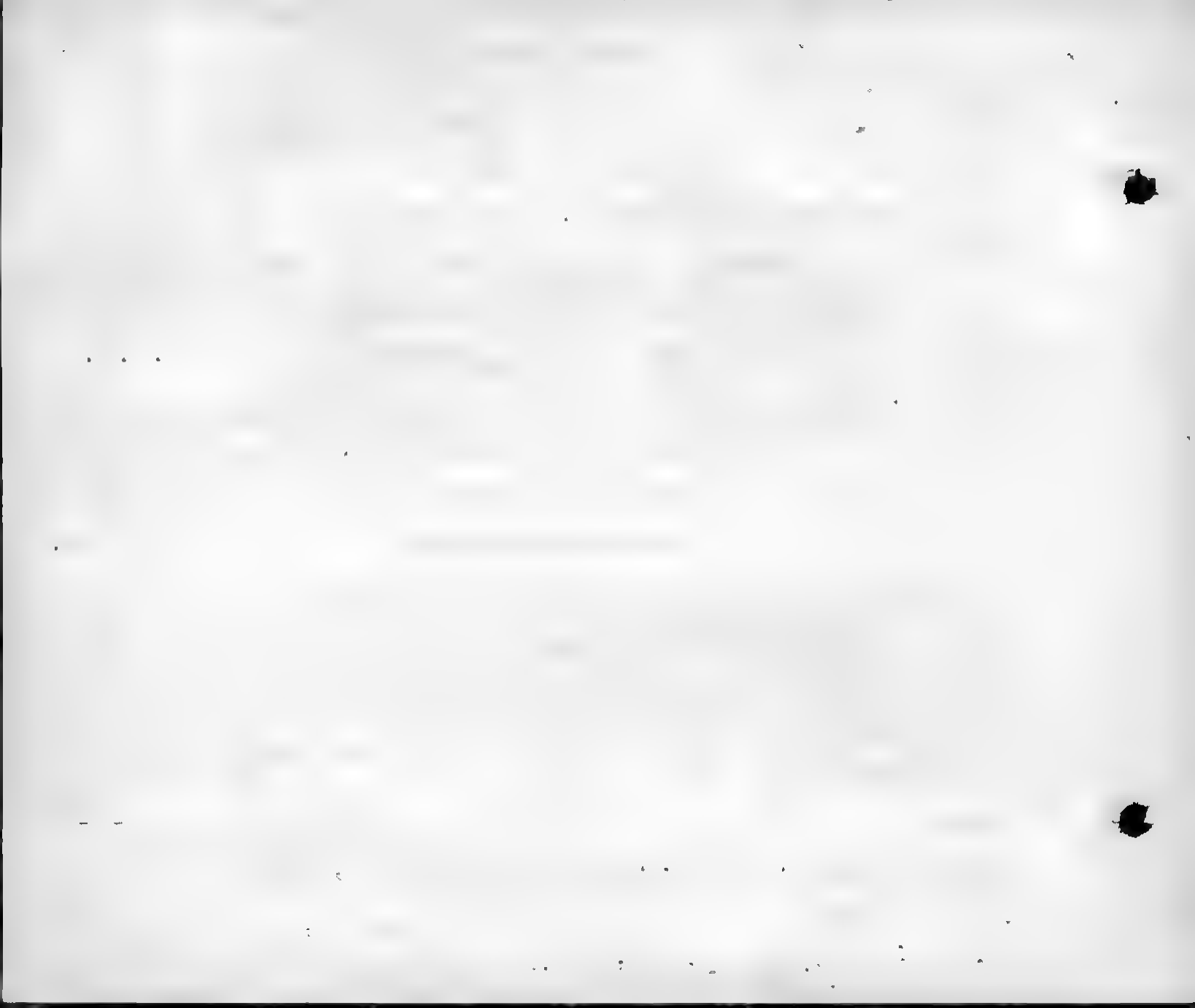
10471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Henrico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>82 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Stephen</b> Middle <b>Wilson</b> Last <b>Sawyer</b>				4. DATE OF DEATH Month <b>September</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 26, 1951</b> 7 yrs	
9. AGE (In years last birthday) <b>7</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Wilbur E. Sawyer</b>			
14. MOTHER'S MAIDEN NAME <b>Jane Hudson</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO <b>None</b>				17. INFORMANT <b>The Clinical Center Medical Record Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphocytic leukemia</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>14 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Meckel's diverticulum</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 8, 1959</b> to <b>September 28, 1959</b> , that I last saw the deceased alive on <b>September 28, 1959</b> , and that death occurred at <b>2:30 P.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jerry S. Trier</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>9-28-59</b>			
PHYSICIAN'S NAME (Type) <b>Jerry S. Trier, M.D.</b>				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-30-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Spotsylvania Co. Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert G. Humphreys</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 1 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10501

## CERTIFICATE OF DEATH

10472

Reg. Dist. No.

1. PLACE OF DEATH COUNTRY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>124 West Marshall Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Boyd</b> Middle <b>Franklin</b> Last <b>Schaff</b>		4. DATE OF DEATH Month <b>September</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 5, 1909</b>
9. AGE (In years last birthday) yrs <b>49</b>		IF UNDER 1 YEAR Months <b>49</b> Days <b>49</b> Hours <b>49</b> Min <b>49</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Noah L. Schaff</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Faraves</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shock (Clinical)</b> <b>1341</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cryptococcosis (lungs &amp; brain)</b> DUE TO (c) <b>Myeloid Metaplasia with pancytopenia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr. 35 min.</b> <b>3 mos.</b> <b>21 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>It subdural, subarachnoid hemorrhage, jaundice</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 6</b> , 19 <b>59</b> , to <b>September 8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>September 8</b> , 19 <b>59</b> , and that death occurred at <b>5:40 AM</b> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED <b>9/8/59</b>	
ACTUAL SIGNATURE <b>Vincent T. Andriole</b> M.D. <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Vincent T. Andriole, M. D.</b>		<b>National Institutes of Health Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept 10, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Fairfax County Va</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. P. DeLoe</b>		ADDRESS <b>Washington, Va.</b>	
24a. REC'D BY REGISTRAR <b>SEP 11 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. King</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10502

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>De.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Congressional Manor San.</u>				d. STREET ADDRESS <u>5104 Scarsdale Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine H Schroeter</u>				4. DATE OF DEATH Month Day Year <u>Sept 27 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-28-1868</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edw. Huber</u>				14. MOTHER'S MAIDEN NAME <u>Eliz. Hammerle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Anatomical Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Found dead in bed</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Marion, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Santos 1756 P.O. Box M.W.D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



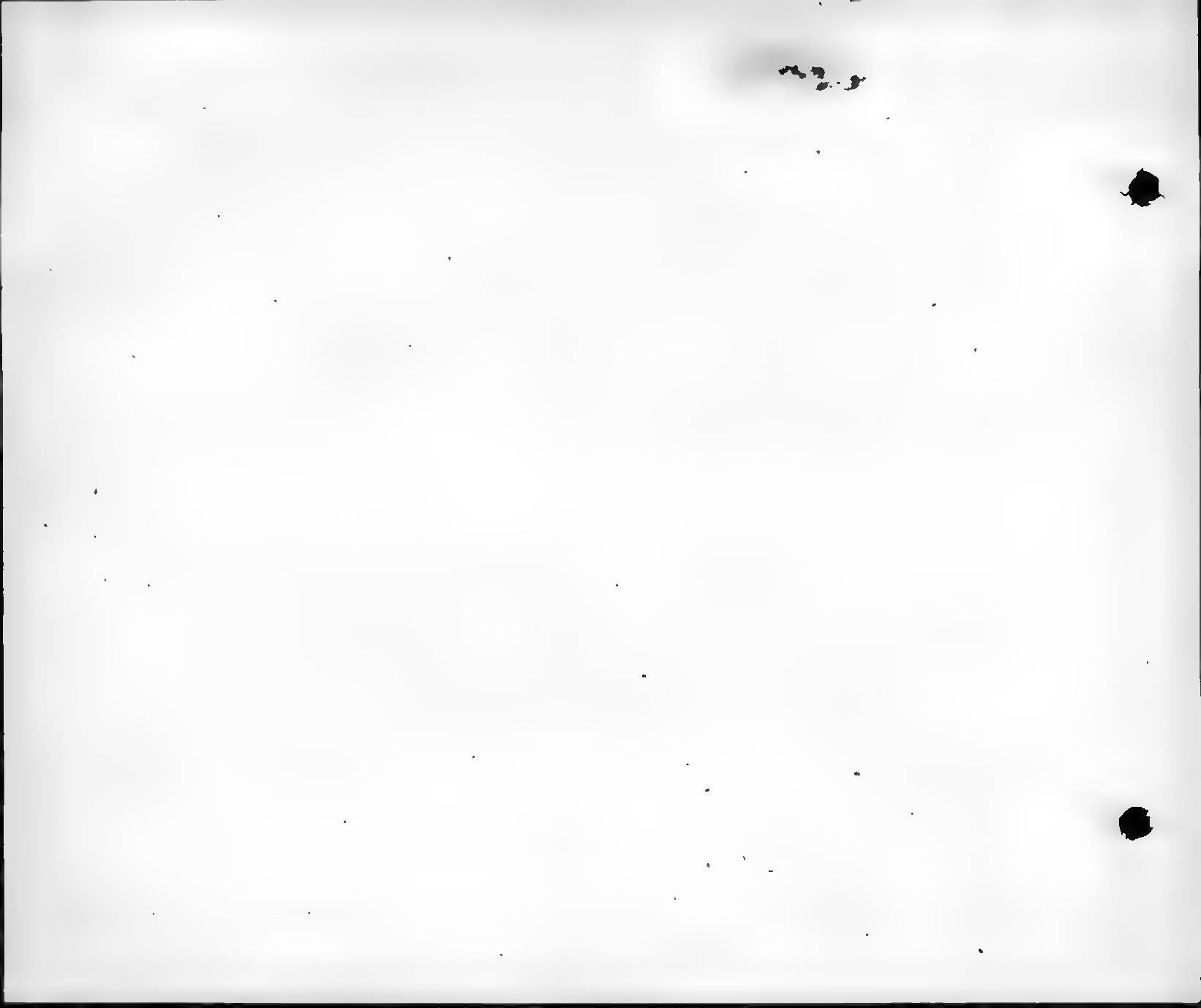
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH Ellen Shutter</u>		4. DATE OF DEATH Month Day Year <u>Sept 16 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-1913</u>
9. AGE (In years last birthday) <u>45 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John L. Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Anna L. Pierson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NO</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Liver Failure</u> DUE TO (c) <u>Carcinoma of Rectum c Metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>6 months</u> <u>1-2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 5, 1959</u> to <u>Aug 16, 1959</u> , that I last saw the deceased alive on <u>Sept 15, 1959</u> , and that death occurred at <u>2:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred W Eastman</u> M.D.		ADDRESS (Street city or town, state) <u>Takoma Park, MD</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred W Eastman</u>		DATE SIGNED <u>9/16/59</u>	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept 9/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Belleville, R.D. Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Wachter, 254 Carroll St NW Wash DC</u>		24. REC'D BY REGISTRAR <u>SEP 17 '59</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10475

Reg. Dist. No.

10503

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5305 Tuscarawas Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lacotha</u> Middle <u>Shannon</u> Last <u>Shannon</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 30, 1887</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Erie, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert O. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Camp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Husband - Item #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>4:00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>30 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hr</u> <u>year</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brochert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROCHERT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>OCT 6 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





10504

## CERTIFICATE OF DEATH

Reg. Dist. No.

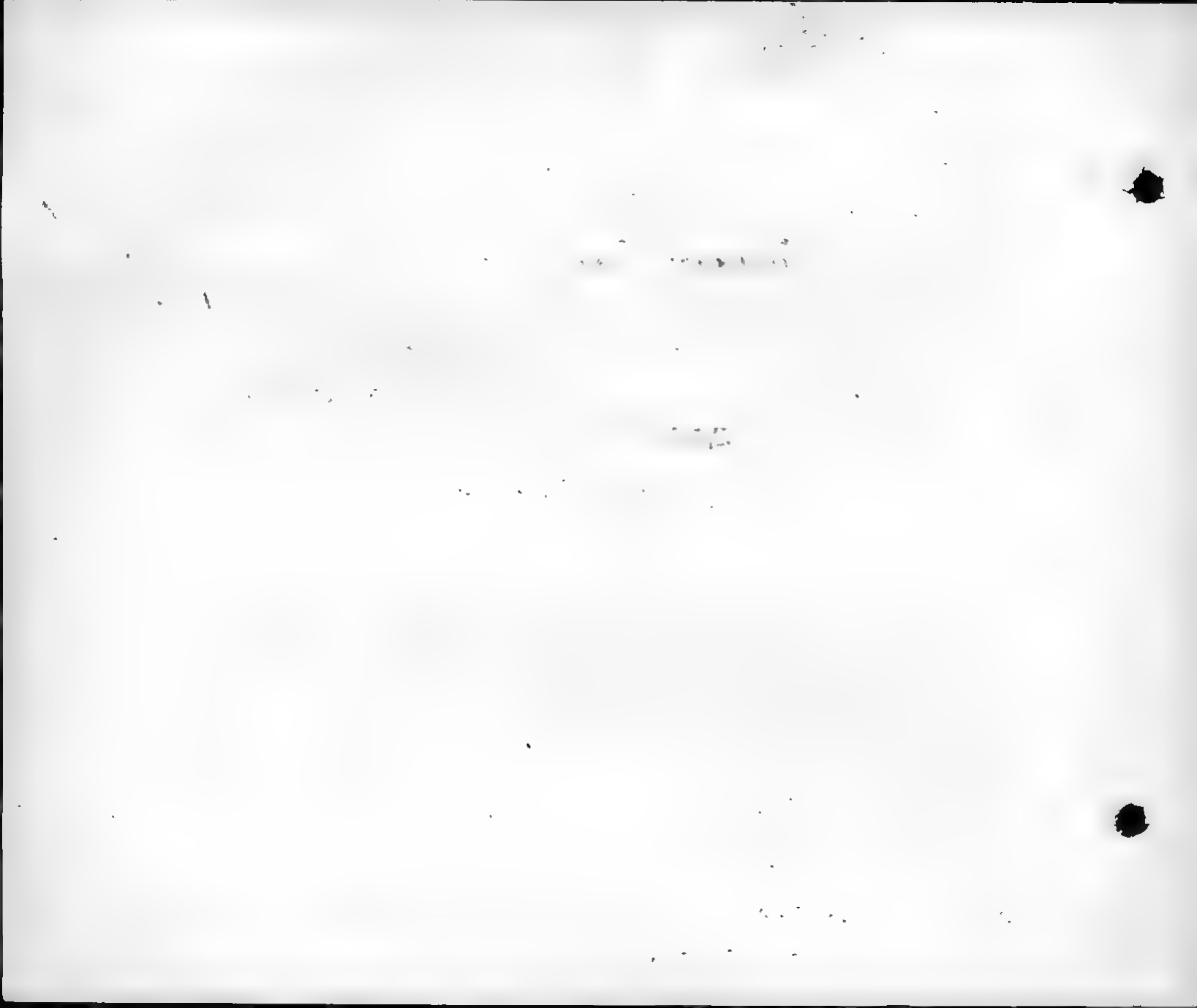
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS - 1 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. STREET ADDRESS <u>1301 BALTIMORE ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>CARR</u> Last <u>SHAN</u>		4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-1880</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR <u>1</u> Months <u>3</u> Days <u>3</u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA-</u>	
13. FATHER'S NAME <u>Wm. H. CARR</u>		14. MOTHER'S MAIDEN NAME <u>EMMA KLEININST</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>212-14-5025</u>	
17. INFORMANT <u>Catherine S. Bridge-daughter - same 2d</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonian Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 46</u> , 19 <u>59</u> , to <u>10 Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 Sept</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W S Murphy</u>		DATE SIGNED <u>10 Sept 59</u>	
PHYSICIAN'S NAME (Type) <u>William S. Murphy</u>		ADDRESS (Street, city or town, state) <u>615 W. Montg. Ave., Rockville, Md</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-12-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 11 59</u>	
ADDRESS <u></u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



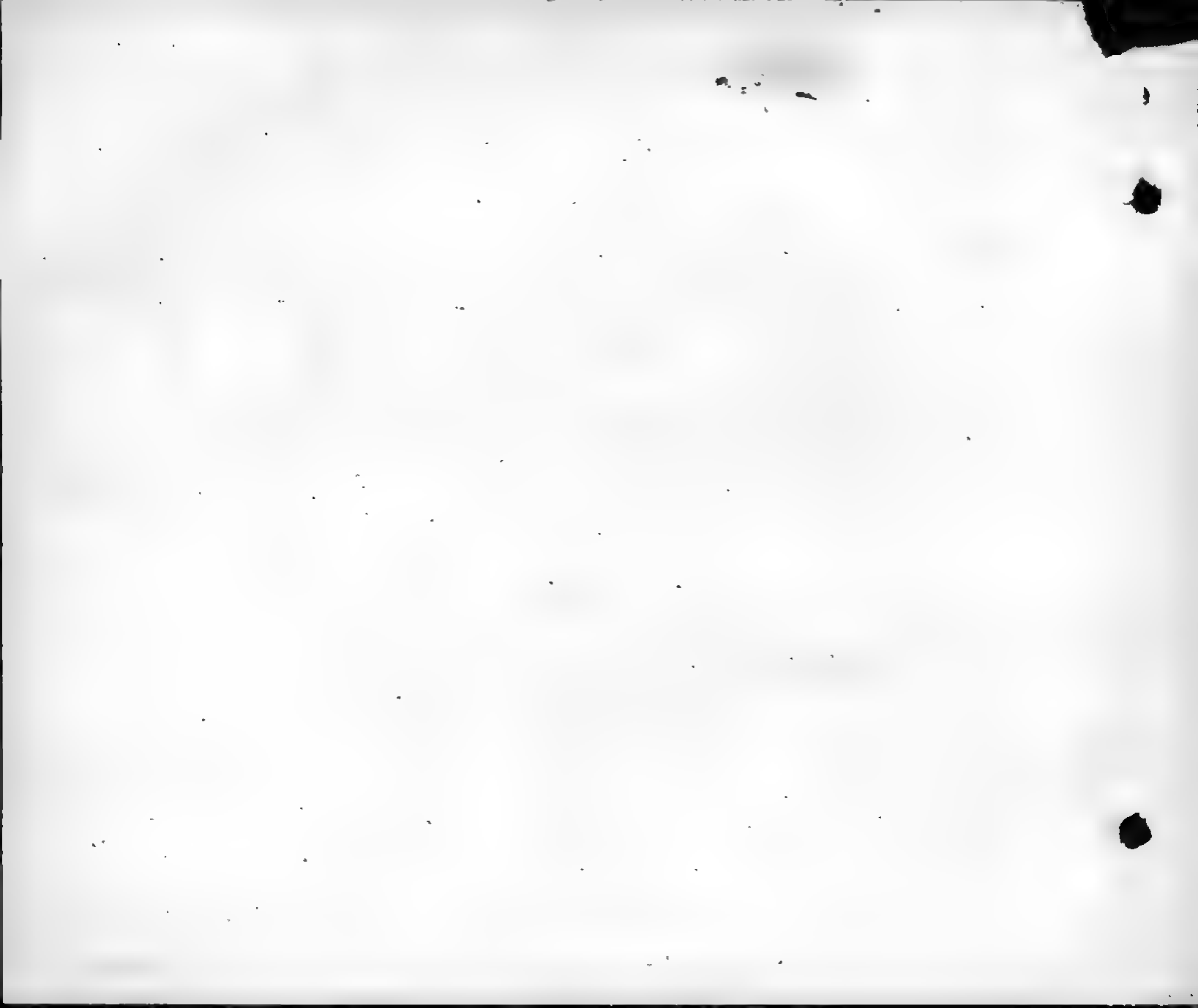
CERTIFICATE OF DEATH

Reg. Dist. No

10365

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Thurmont Park</i>		c. LENGTH OF STAY IN 1b <i>7 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Grace</i> Middle <i>Paul</i> Last <i>Shoemaker</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>30</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-6-83</i>
9. AGE (in years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>24</i> Hours <i></i> Min. <i></i>	11. IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>D.C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>US</i>		13. FATHER'S NAME <i>Marcellus Dunn</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Groggs</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Washington Sanitarium &amp; Hospital</i> Address <i>Frederick, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4-20-1</i> DUE TO <i>Acute coronary occlusion and myocardial failure</i> (b) DUE TO <i>Generalized arteriosclerosis</i> (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hrs.</i>  <i>10 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9-30-</i> 19 <i>59</i> , to <i>9-30-</i> 19 <i>59</i> , that I lost saw the deceased alive on <i>9-30-</i> 19 <i>59</i> , and that death occurred at <i>4:00</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>N. C. Shoemaker M.D.</i>		ADDRESS (Street, city or town, state) <i>8005 Woodbury Drive Silver Spring, Md.</i> DATE SIGNED <i>9/30/59</i>	
PHYSICIAN'S NAME (Type) <i>N. C. Shoemaker, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/3/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>DATE OCT 5/2 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10479

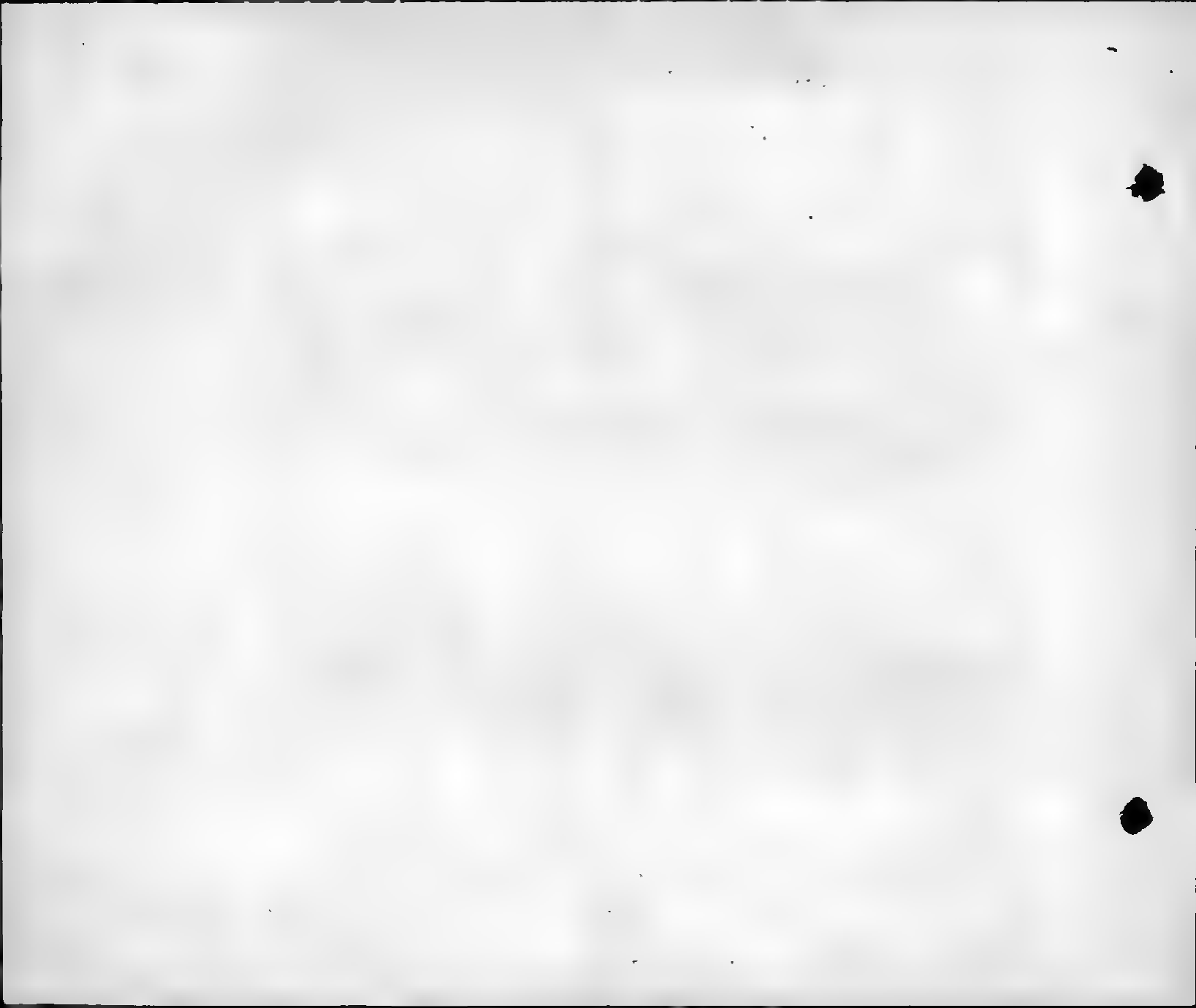
Reg. Dist. No.

10505 4.15 4.15 248 9-16-59 et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1919 La Fayette Drive</u>			
				d. STREET ADDRESS <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alexander John Singer</u>				4. DATE OF DEATH Sept <u>14</u> Month <u>8</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 1 1923</u>	
9. AGE (in years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>3</u> Min. <u>4</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
13. FATHER'S NAME <u>B. Alexander Singer</u>				14. MOTHER'S MAIDEN NAME <u>Callahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>144-18-2344</u>		17. INFORMANT <u>Rosalie Singer above</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>							
4 <u>...</u> DUE TO							
Conditions, if any, which gave rise to immediate cause (b)							
(c), stating the underlying cause last. DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>History of previous coronary disease</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-8-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler-1331 E. Montg. Ave. Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Kraw</u>	

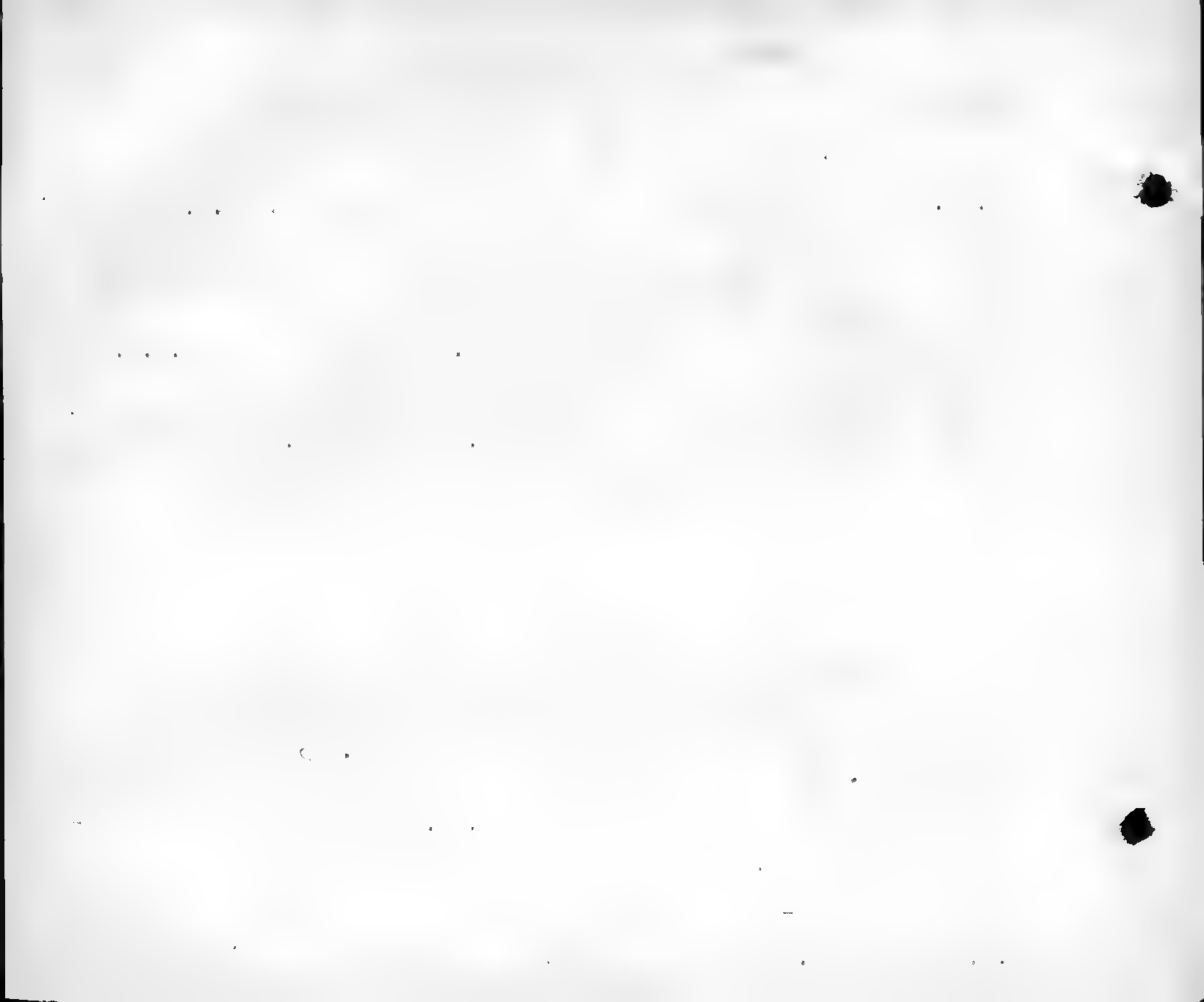
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



V5 A15 (4)  
15M 9/5B

V5 A15 (4)  
15M 9/5B





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

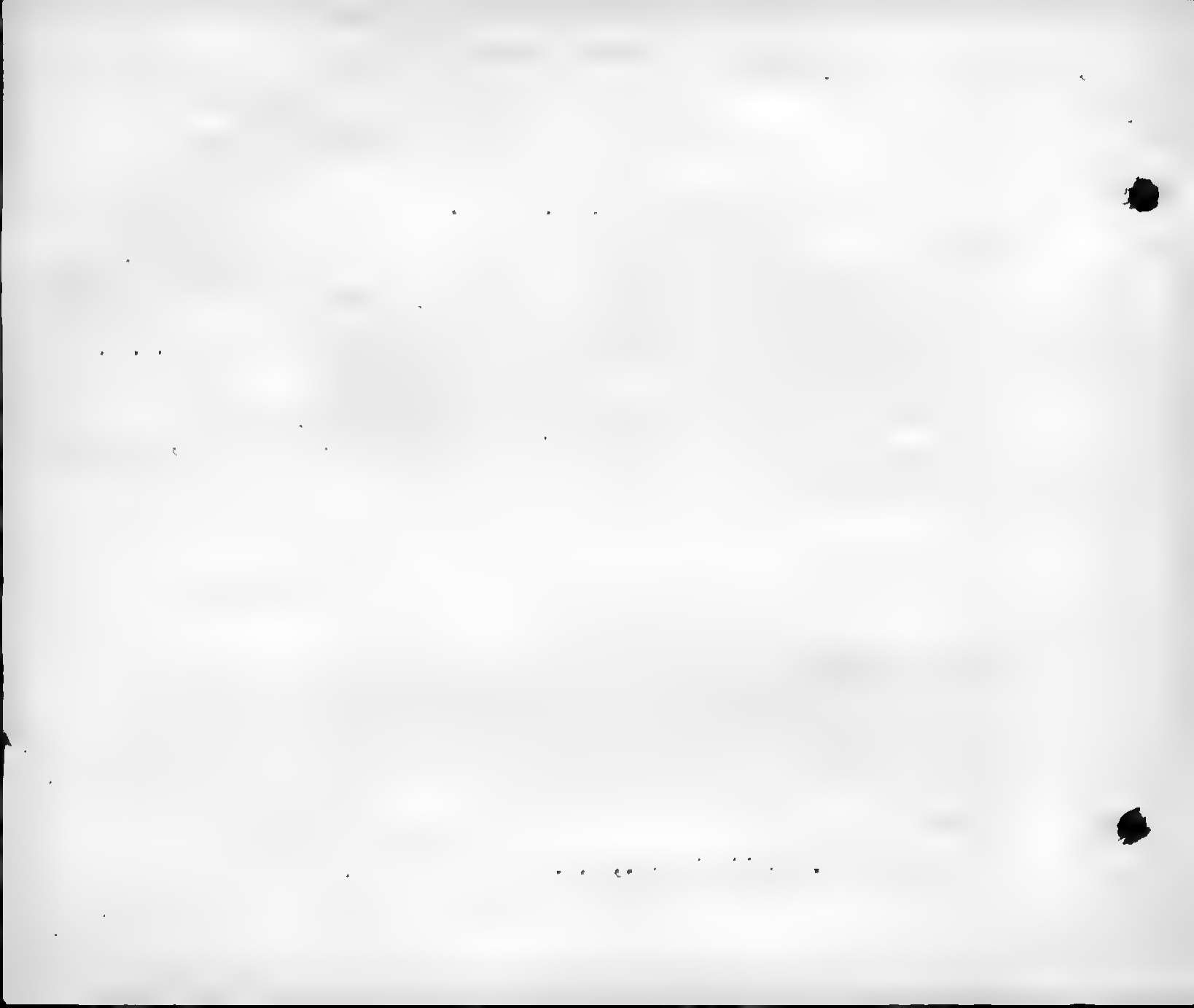
10481

10507

## CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>75</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Center</b>		d. STREET ADDRESS <b>R. D. 1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Priscilla</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>September</b> Day <b>14</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 28, 1910</b>	
9. AGE (In years last birthday) yrs. <b>49</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>11</b> Hours <b>30</b> Min <b>00</b>		IF UNDER 24 HRS Hours <b>3</b> Min <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jacob Putt</b>				14. MOTHER'S MAIDEN NAME <b>Clara Dickey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Increased Intracranial pressure</b> DUE TO (b) <b>Secondary to Brain tumor</b> DUE TO (c) <b>Cardio Respiratory Failure</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 - 11 - 59</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 7, 19 59</b> , to <b>September 14, 19 59</b> , that I last saw the deceased alive on <b>September 14, 19 59</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>Joseph A. Adamkiewicz Jr., M.D.</b>				PHYSICIAN'S NAME (Type) <b>Joseph A. Adamkiewicz Jr., M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/18/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Indiana County, Penn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b> ADDRESS <b>Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>SEP 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton E. Jones</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10508

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

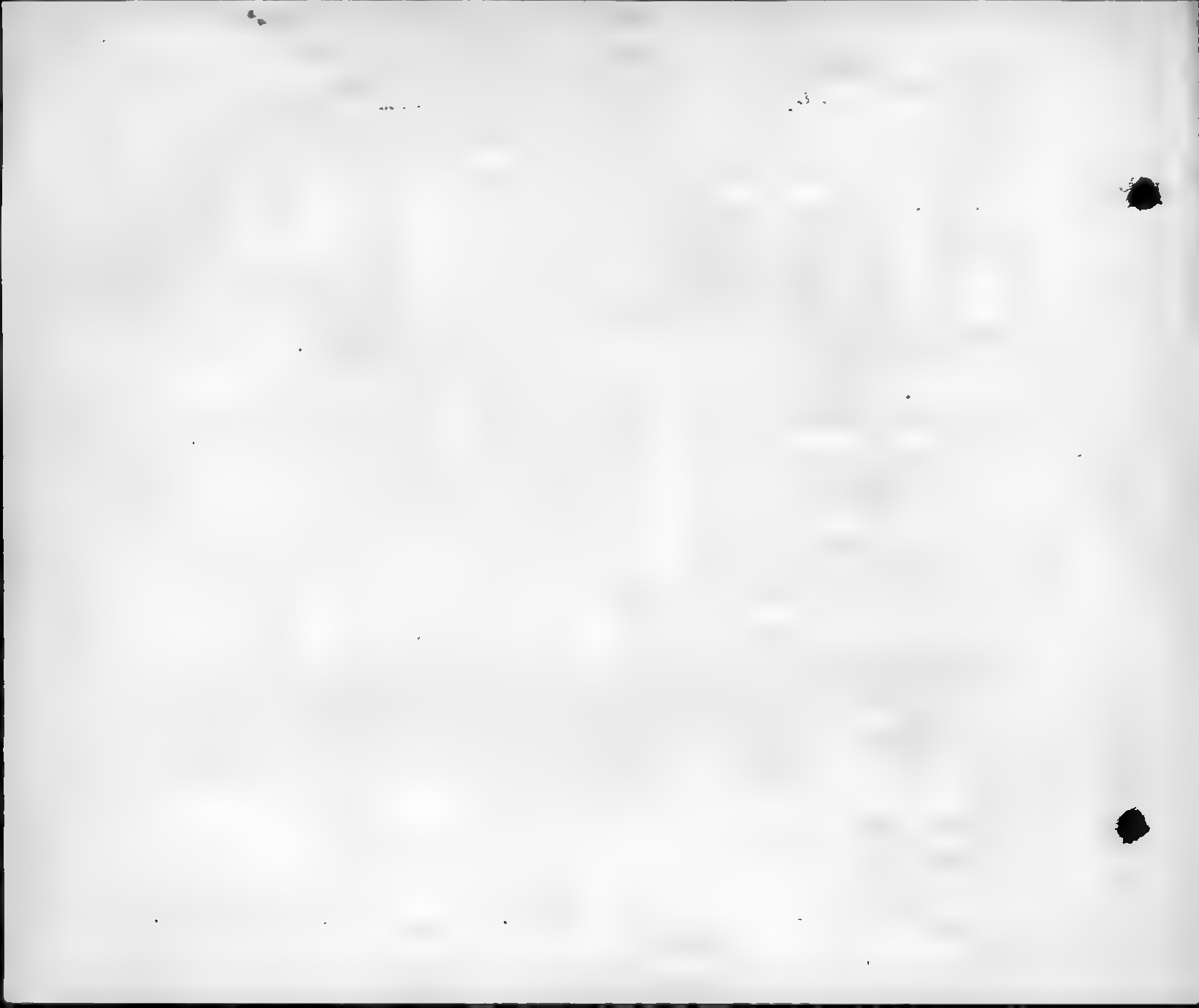
Item 11 Film 248 9-21-59 et

10482

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ge. Ave. near Burlington Ave</b>				d. STREET ADDRESS <b>6103 Fair Oak Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>Lee</b> Last <b>Smoot</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1920</b> <b>April 13, 1920</b>	9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Roy O. Smoot</b>				14. MOTHER'S MAIDEN NAME <b>Della Bly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>229-18-1859</b>		17. INFORMANT <b>Doris Smoot</b> Address <b>6103 Fair Oak Ave.</b>			
1B CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary occlusion</b> DUE TO (c) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>sudden</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Collapsed while driving truck which ran into tel. pole.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>No evidence of injury</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>9/14/59</b>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-17-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>				ADDRESS <b>5305 Harford Rd</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 16 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kenna</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



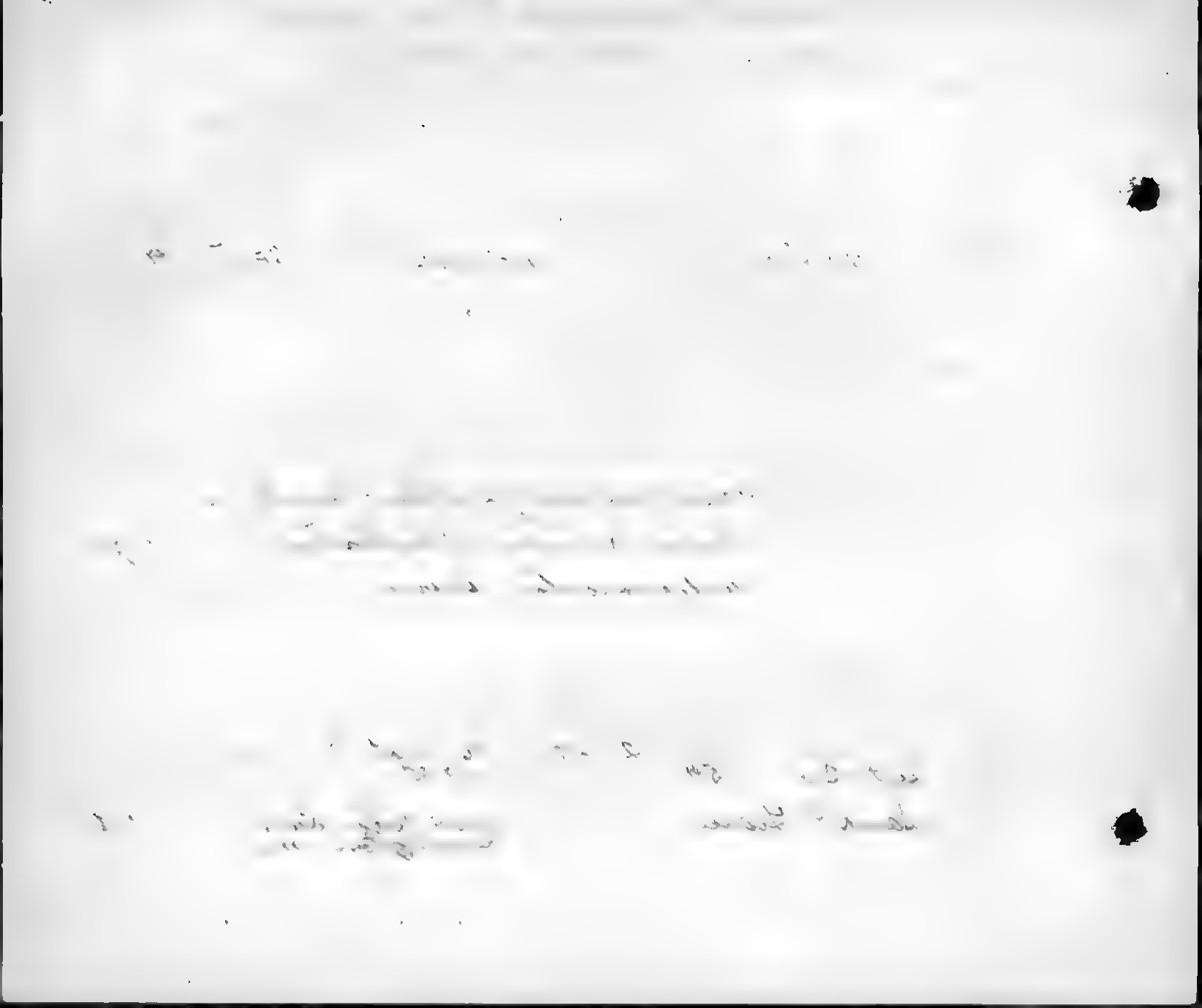
10509

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 2, Belair</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Asbury Methodist Home for Aged, Inc.</b>		d. STREET ADDRESS <b>128</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Smothers</b> Last <b>Smothers</b>		4. DATE OF DEATH Month <b>SEPT</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Mother not married</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Smothers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Massive pulmonary embolism &amp; pneumonia</b> <b>433.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic arrhythmic fibrillation</b> DUE TO (c) <b>Cardiovascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-29</b> , 19 <b>56</b> , to <b>Sept 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 2nd</b> , 19 <b>59</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sarah E. Glover</b>		ADDRESS (Street, city or town, state) <b>10128 Cedar Lane Kensington, Md</b>	
PHYSICIAN'S NAME (Type) <b>Sarah E. Glover</b>		DATE SIGNED <b>9-9-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/12/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Smith's Chapel Meth. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Aberdeen, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tidener</b>		ADDRESS <b>1700 S. Route 17, Bel Air, Md</b>	
24a. REC'D BY REGISTRAR <b>SEP 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

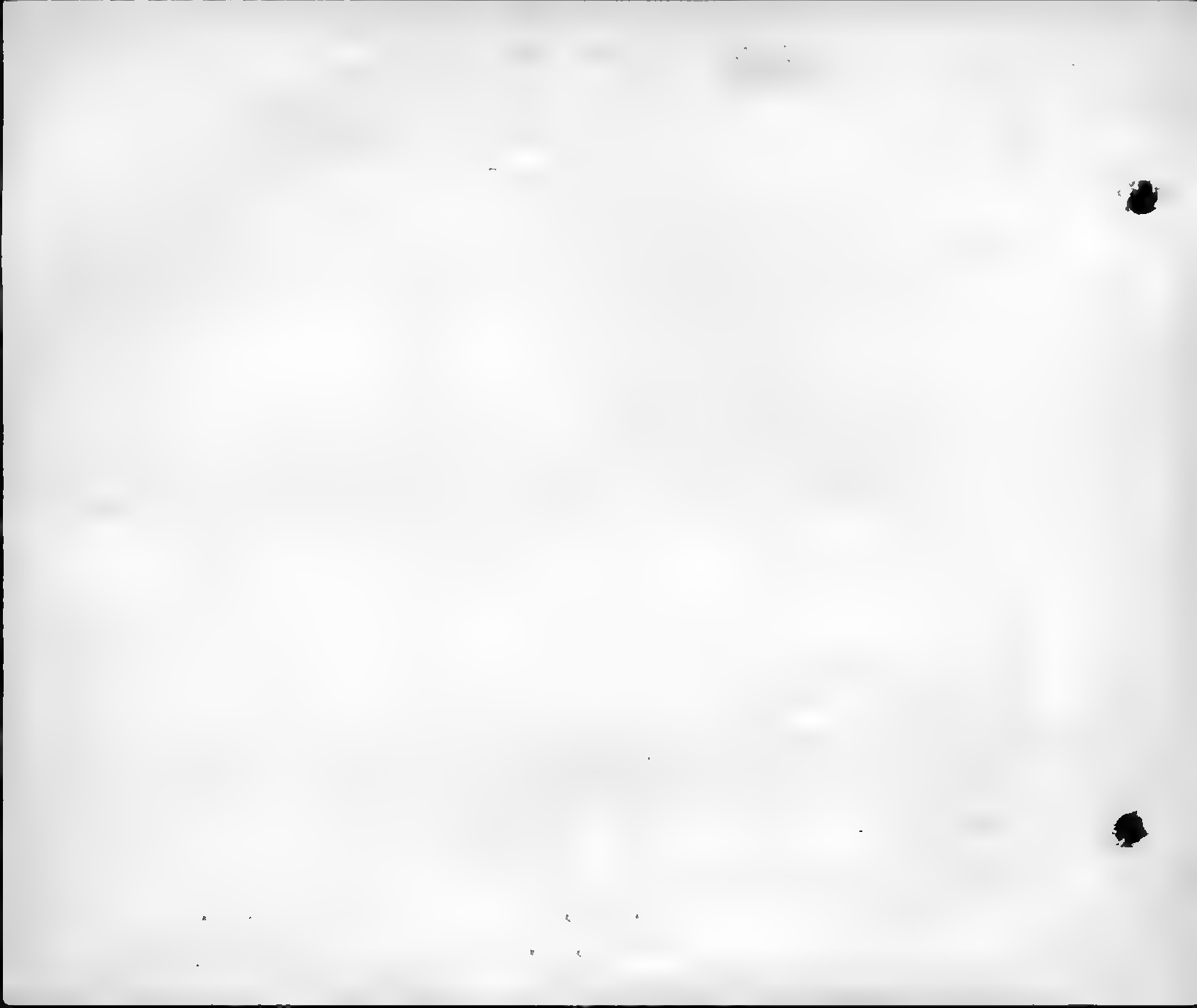
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>2 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC. SILVER SPRING</b>				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>C-121 NORWOOD ROAD</b> d. STREET ADDRESS <b>SILVER SPRING</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3 NAME OF DECEASED (Type or print) <b>MICHAEL LEON SNOWDEN</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>13</b> Year <b>19 59</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/11/59</b>		9. AGE (In years last birthday) yrs. <b>2</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>CHARLES E. SNOWDEN</b>								14. MOTHER'S MAIDEN NAME <b>JACQUELINE JOHNSON</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16 SOCIAL SECURITY NO.				17 INFORMANT <b>HOSPITAL RECORDS, OLNEY, MD.</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Prematurity &amp; Immaturity</b> <b>Partial atelectasis of lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>DAMASCUS, MARYLAND</b>		(County)		(State)					
21. I certify that I attended the deceased from <b>SEPTEMBER 11 1959</b> , to <b>SEPTEMBER 13 1959</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>10:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>DAMASCUS, MARYLAND</b> DATE SIGNED																	
ACTUAL SIGNATURE <b>G. F. MEADORS, M.D.</b>				M.D.				PHYSICIAN'S NAME (Type) <b>G. F. MEADORS, M.D.</b>				ADDRESS <b>DAMASCUS, MARYLAND</b>					
22a BURIAL CREMATION, REINTERMENT <b>Burial</b>				22b. DATE THEREOF <b>9/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion,</b>				22d. LOCATION (City, town, or county) (State) <b>Bookeville, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert R. Snowden</b>						ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kinsale</b>							

2073286XV1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove warbur papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

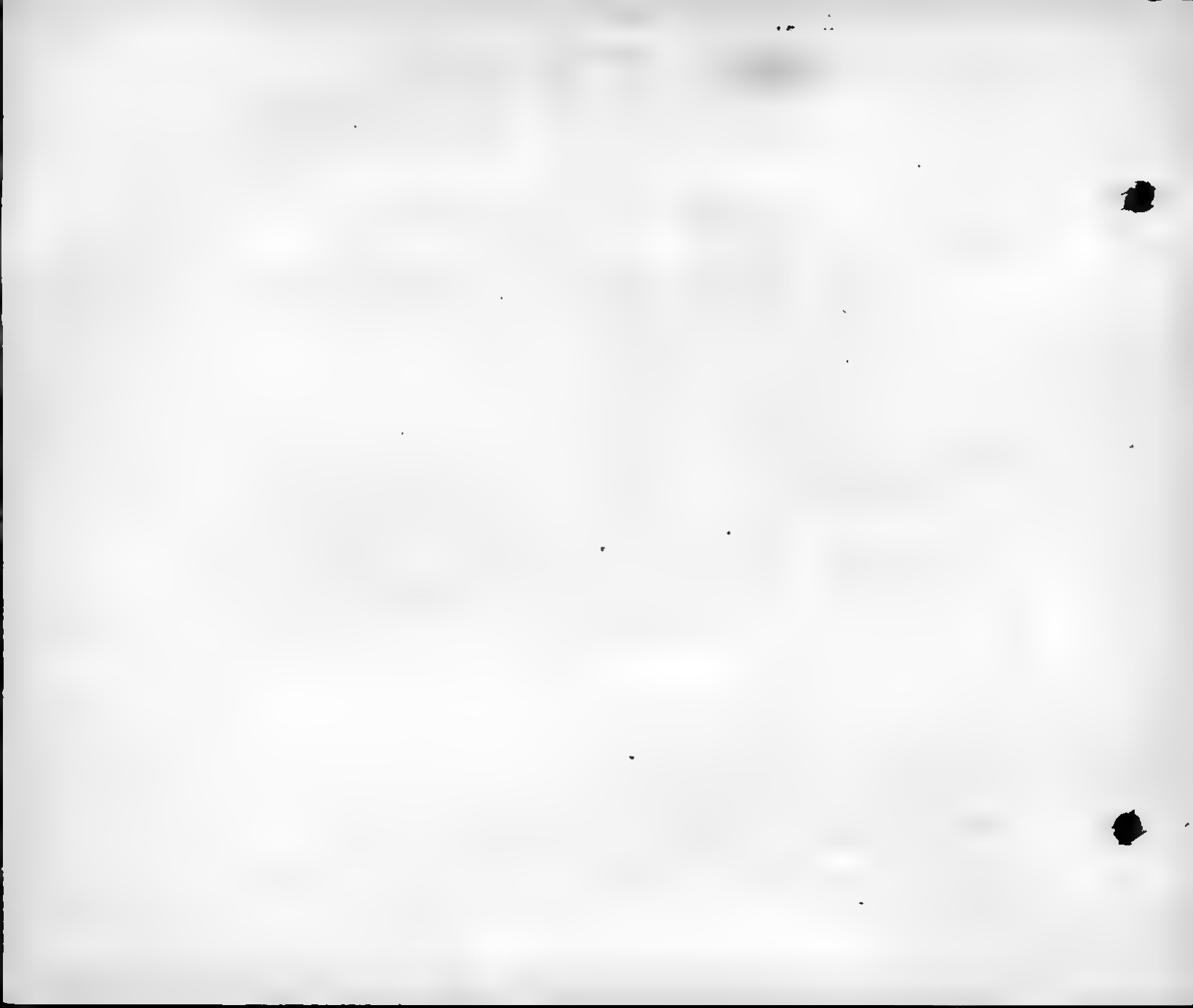
Reg. Dist. No.

10367

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San &amp; Hosp.</u>		d. STREET ADDRESS <u>811 Malcolm Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>(none)</u> Last <u>Solomon</u>		4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-97</u>
9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Mr. Isaac Simon</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Son - Mr. Stanley Solomon</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 7</u> , 19 <u>59</u> , to <u>SEPT 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>SEPT 15</u> , 19 <u>59</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>8723 Kinner Branch Rd. Silver Spring, Md.</u>	
DATE SIGNED <u>SEP 18 1959</u>		PHYSICIAN'S NAME (Type) <u>Stanley Solomon</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10486

Reg. Dist. No.

10511

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg (rural)</u>			
c. LENGTH OF STAY IN 1b <u>21 yrs</u>				d. STREET ADDRESS <u>Burdette Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Burdette Rd</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Albert Casimir Somers</u>				4. DATE OF DEATH Month Day Year <u>Sept 22 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-4-1887</u>	
9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer 4-8-90s</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>N. J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Peter Somoracki</u>				14. MOTHER'S MAIDEN NAME <u>Rosalie Hodnidska</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW. I</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mae Somers (wif.) Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-22-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHELT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Mobaworth</u> ADDRESS <u>Danascus, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10512

## CERTIFICATE OF DEATH

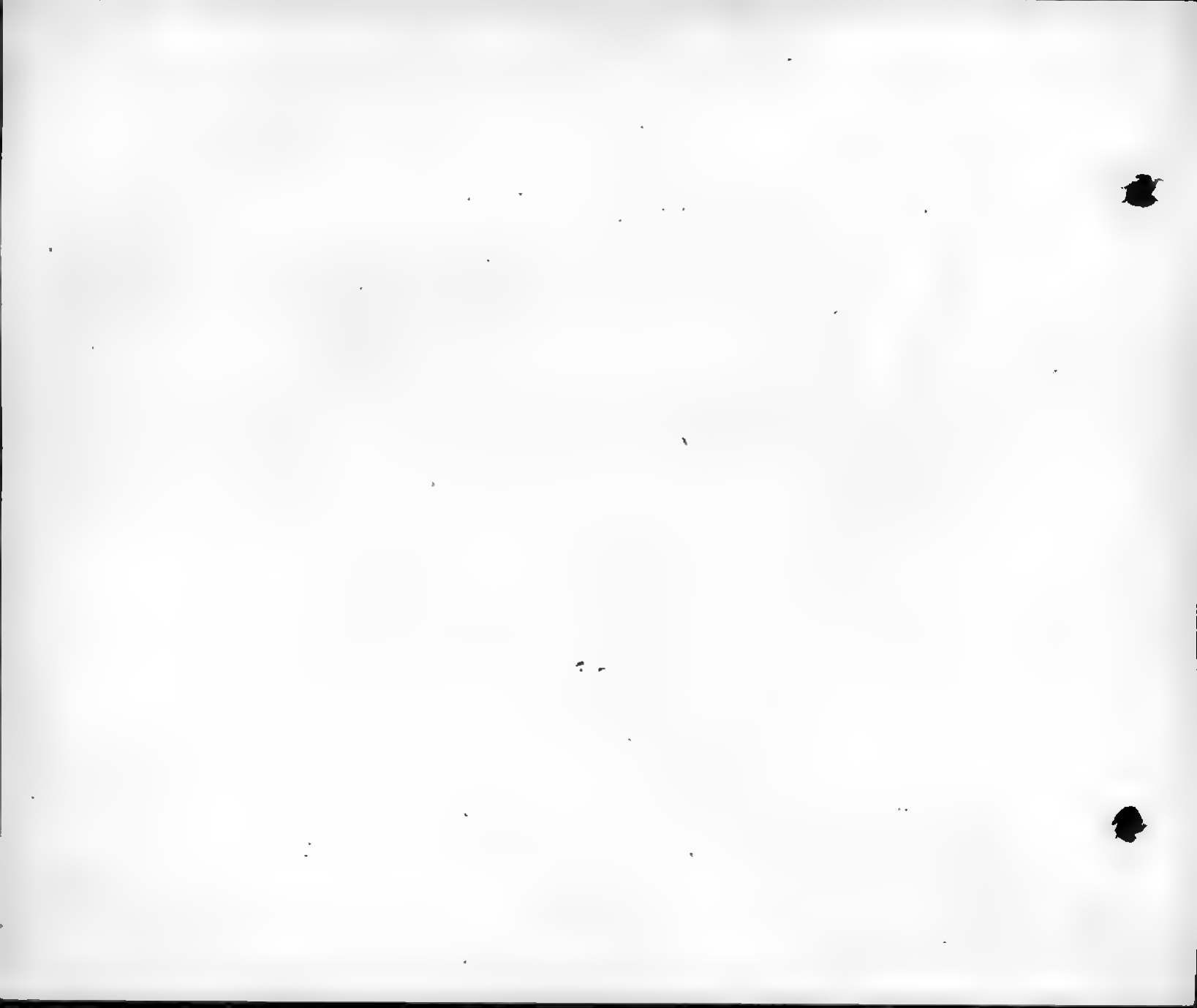
Reg. Dist. No.

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Nursing Home</u>				e. STREET ADDRESS <u>5315 Conn. Ave. N.W.</u>			
3 NAME OF DECEASED (Type or print) <u>Fred</u> First <u>C.</u> Middle <u>Spaulding</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-1882</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Albert Spaulding</u>				14. MOTHER'S MAIDEN NAME <u>Nora Colburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-44-1591</u>		INFORMANT <u>Mary F. Spaulding, Same as 2 (Wife)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cardio Respiratory Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary heart disease</u> DUE TO <u>Cardiac Asthma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 18, 1959</u> to <u>Sept 2, 1959</u> that I last saw the deceased alive on <u>Sept 2, 1959</u> and that death occurred at <u>12 M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. H. Matinez</u> M.D.		ADDRESS (Street, city or town, state) <u>Wash. Bldg. Beltsville</u> DATE SIGNED					
PHYSICIAN'S NAME (Type) <u>F. H. Matinez</u> M.D.							
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Medford, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber Co.</u> ADDRESS <u>1400 Chapin St. NW Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Collins &amp; Thorne</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

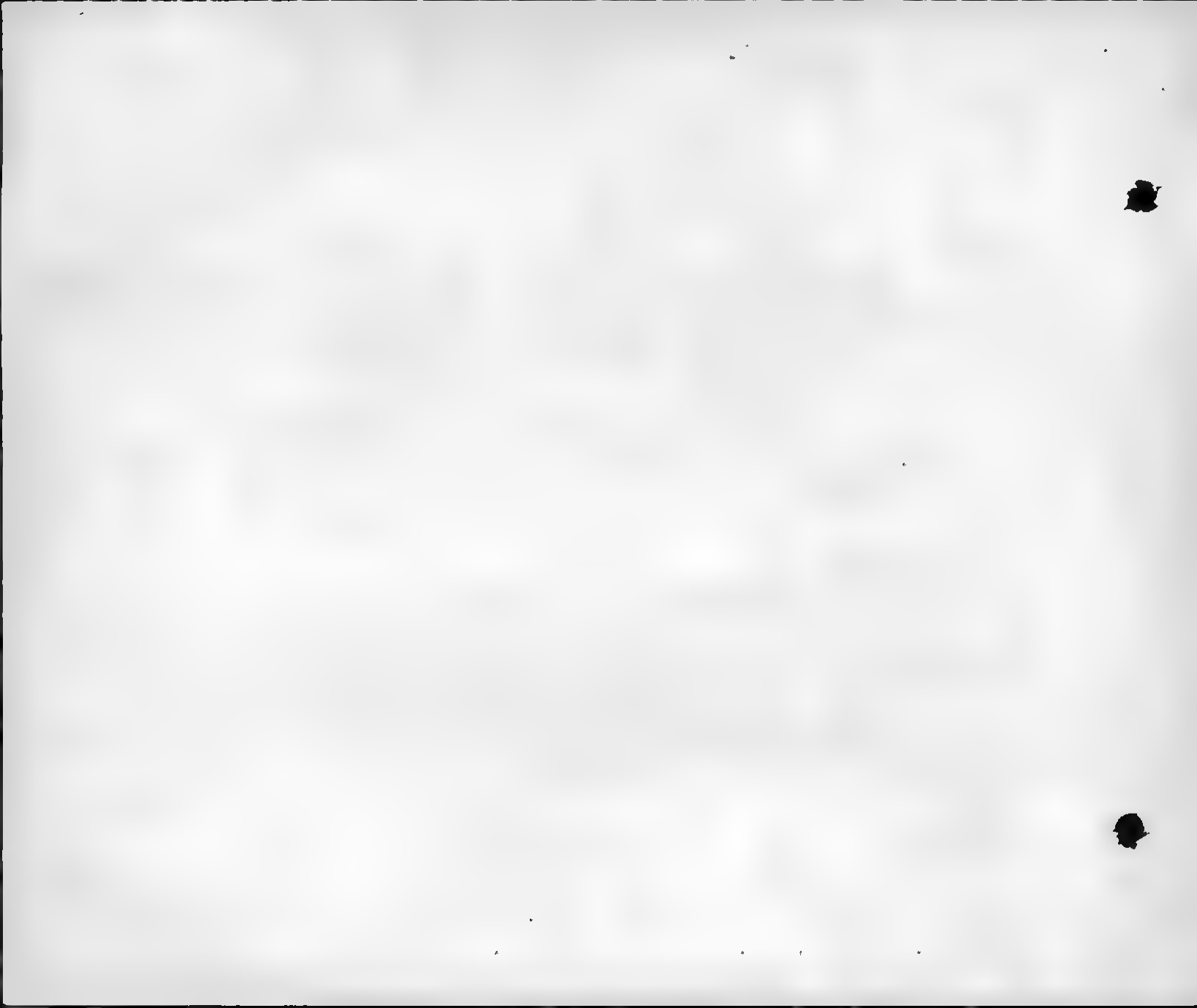
Reg. Dist. No.

10513

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 wk</u>		d. STREET ADDRESS <u>1701 East West Highway</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1701 East West Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>Emily</u> Last <u>Stanley</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Pa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George P. Stryker</u>		14. MOTHER'S MAIDEN NAME <u>Emily Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Leslie W. Stanley - Slim 2</u>	
17. INFORMANT <u>Leslie W. Stanley - Slim 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hanging</u> DUE TO (c) <u>hanging</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fond hanging by neck at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>5</u> <u>9-19</u> <u>1969</u> Hour <u>5</u> <u>p.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>md</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-19-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





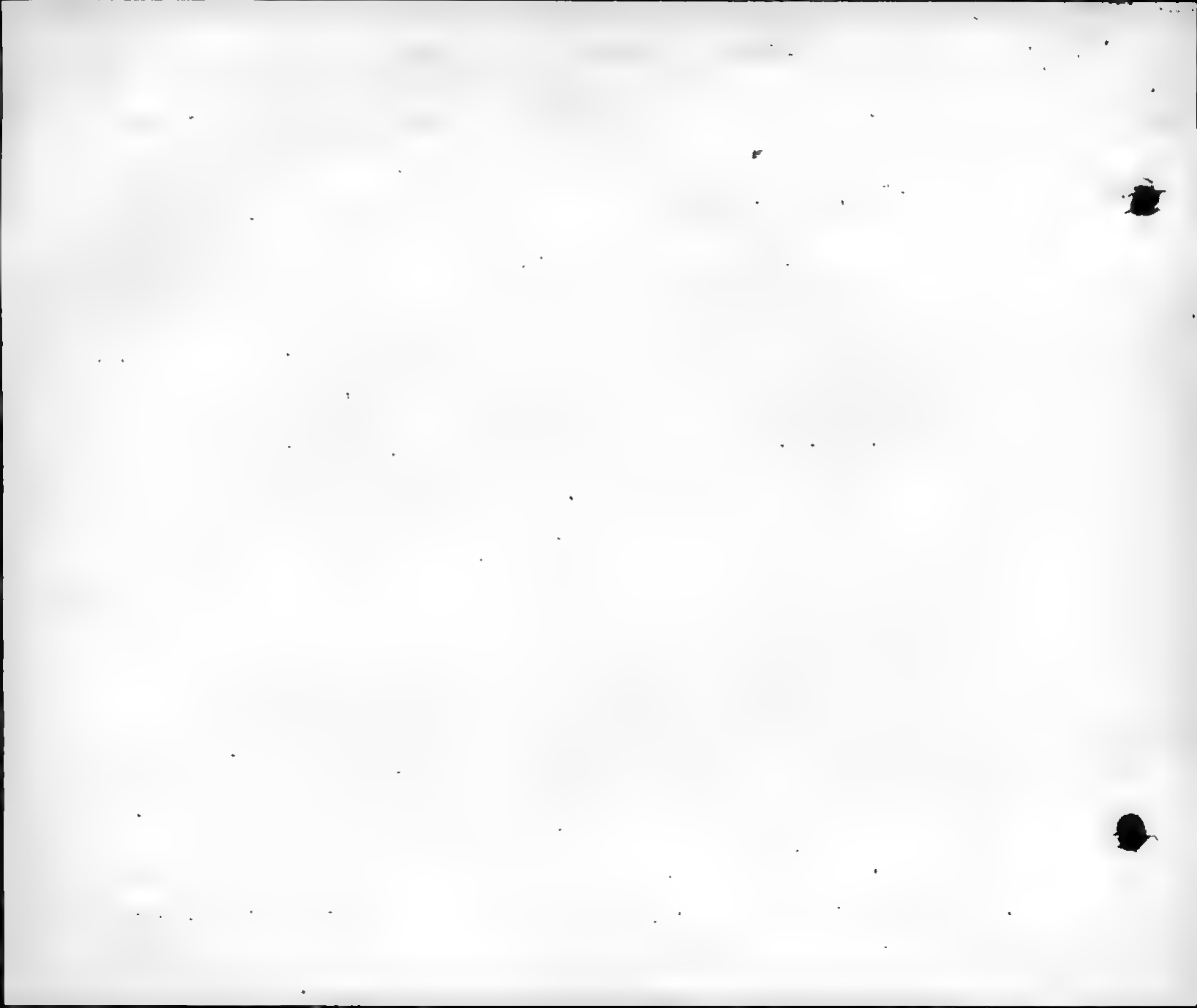
10514

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>26 Hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>A.</u> Last <u>Steitz</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/5/84</u>	
9. AGE (In years last birthday) <u>75</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Andersen</u>				14. MOTHER'S MAIDEN NAME <u>Louis e Funk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1. 2. 3. Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of large bowel</u> (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 5, 1959</u> to <u>9/30, 1959</u> that I last saw the deceased alive on <u>9-29, 1959</u> and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. D. Joyner</u> M.D.				ADDRESS (Street, city or town, state) <u>8106 Maple Ridge Rd Bethesda, Md</u> DATE SIGNED <u>9/30/59</u>			
PHYSICIAN'S NAME (Type) <u>William T. Joyner</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-Bur.</u>		22b. DATE THEREOF <u>10-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Queens County, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS _____				24a. REC'D. BY REGISTRAR <u>OCT 5 1959</u> DATE _____		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

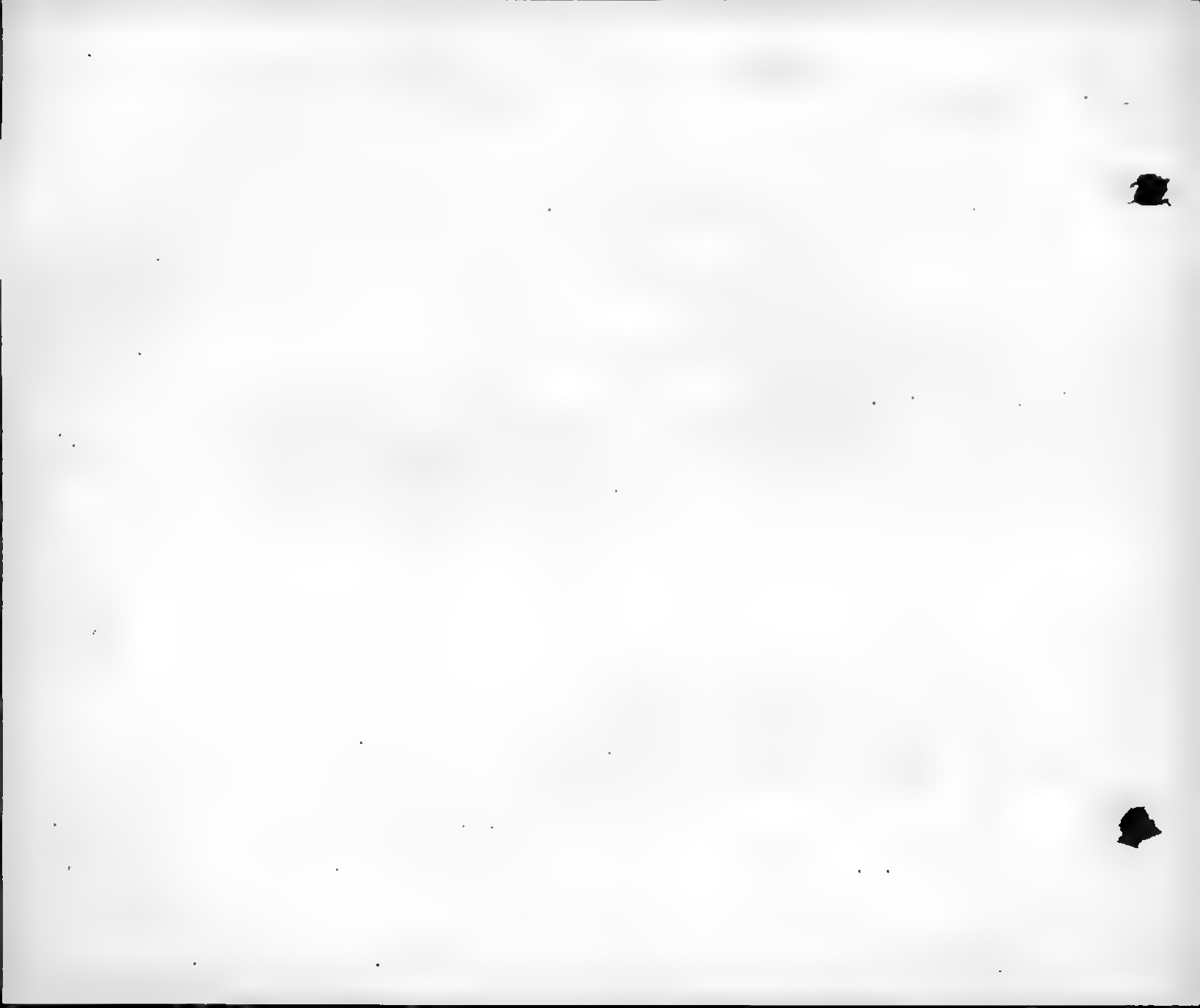
Reg. Dist. No. 215

10515

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>↓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>55 days</b>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Fred STEPHENS</b>				4. DATE OF DEATH Month Day Year <b>September 24 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-5-34</b>	
9. AGE (In years last birthday) <b>25</b> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min			
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service station</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. ATTENDANT <b>William E. STEPHENS</b>				14. MOTHER'S MAIDEN NAME <b>Catherine CONTE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>1953-1955</b>				16. SOCIAL SECURITY NO. <b>535 32 5777</b>			
17. INFORMANT <b>(Wife) Barbara J. Stephens</b>				Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension Dissecting</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>31 July</b> , 19 <b>59</b> , to <b>24 Sept</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>24 September 19 59</b> , and that death occurred at <b>11:34 PM</b> . I am the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>9-25-59</b>							
ACTUAL SIGNATURE <b>William P. Baker</b>				M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>			
PHYSICIAN'S NAME (Type) <b>W. P. BAKER LT MC USN</b>				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-29-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				ADDRESS <b>Funeral Home 7557 Wisconsin Ave. Bethesda Md.</b>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

SEP 30 59

Arthur E. Kraus



10516

CERTIFICATE OF DEATH

10491

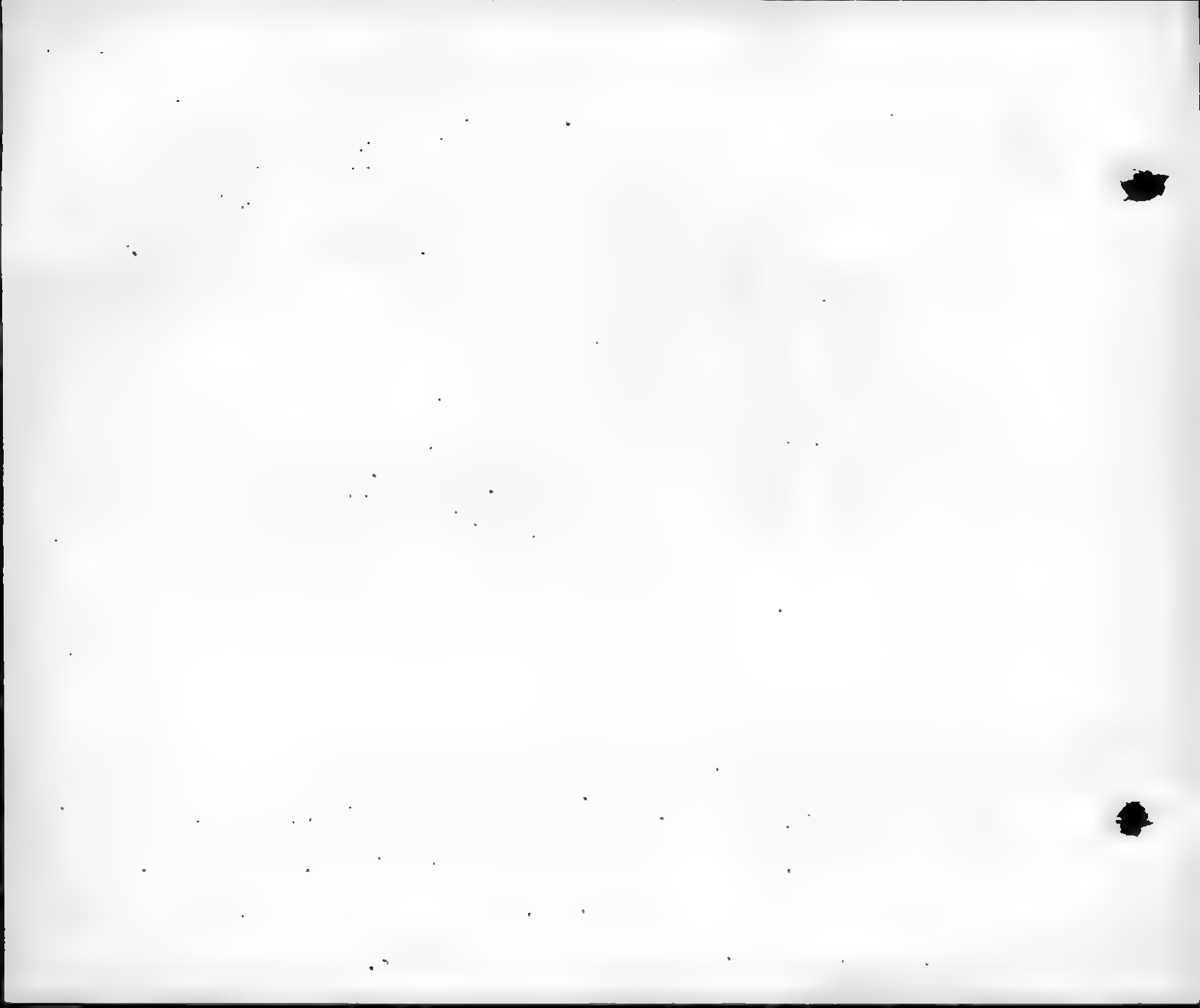
Reg. Dist. No.

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brittishburg</u> d. STREET ADDRESS <u>Route #2 Box 65</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>STEVENSON</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17, 1939</u>
9. AGE (In years lost birthday) yrs. <u>16</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOT GIVEN</u>		14. MOTHER'S MAIDEN NAME <u>BETTY ANN STEVENSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Immaturity &amp; atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u> <u>16 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>59</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20e. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>59</u> , to <u>9-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-18</u> , 19 <u>59</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Francis J. Troendle</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Francis J. TROENDLE</u>		809 Viers Mill Rd. Rockville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>	22d. LOCATION (City, town, or county) <u>Bethesda Maryland</u> (State) <u>—</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital 8600 Old Georgetown Rd. Bethesda</u>		24a. REC'D BY REGISTRAR <u>ACT 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. K...</u>			

1074217XU1



10517

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>28 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. STREET ADDRESS <u>SOUTH LAWN LANE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND STEWART</u>				4. DATE OF DEATH Month Day Year <u>9 13 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15 1876</u>	9. AGE (In years last birthday) <u>83 yrs.</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STEWART</u>				14. MOTHER'S MAIDEN NAME <u>FRANCIS JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>		INFORMANT (SISTER) Address <u>ROCKVILLE, MD. LINNA THOMPSON 62 W. MOORE AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>trauma</u> DUE TO <u>Congestive Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic HD</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>several yrs</u> <u>yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the parathyroid glands</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>9-13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 13</u> , 19 <u>59</u> , and that death occurred at <u>10</u> <u>PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____							
ACTUAL SIGNATURE <u>L. B. Boudette Huntley M.D.</u>				DATE SIGNED <u>9/14/59</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Smaunden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours of death.





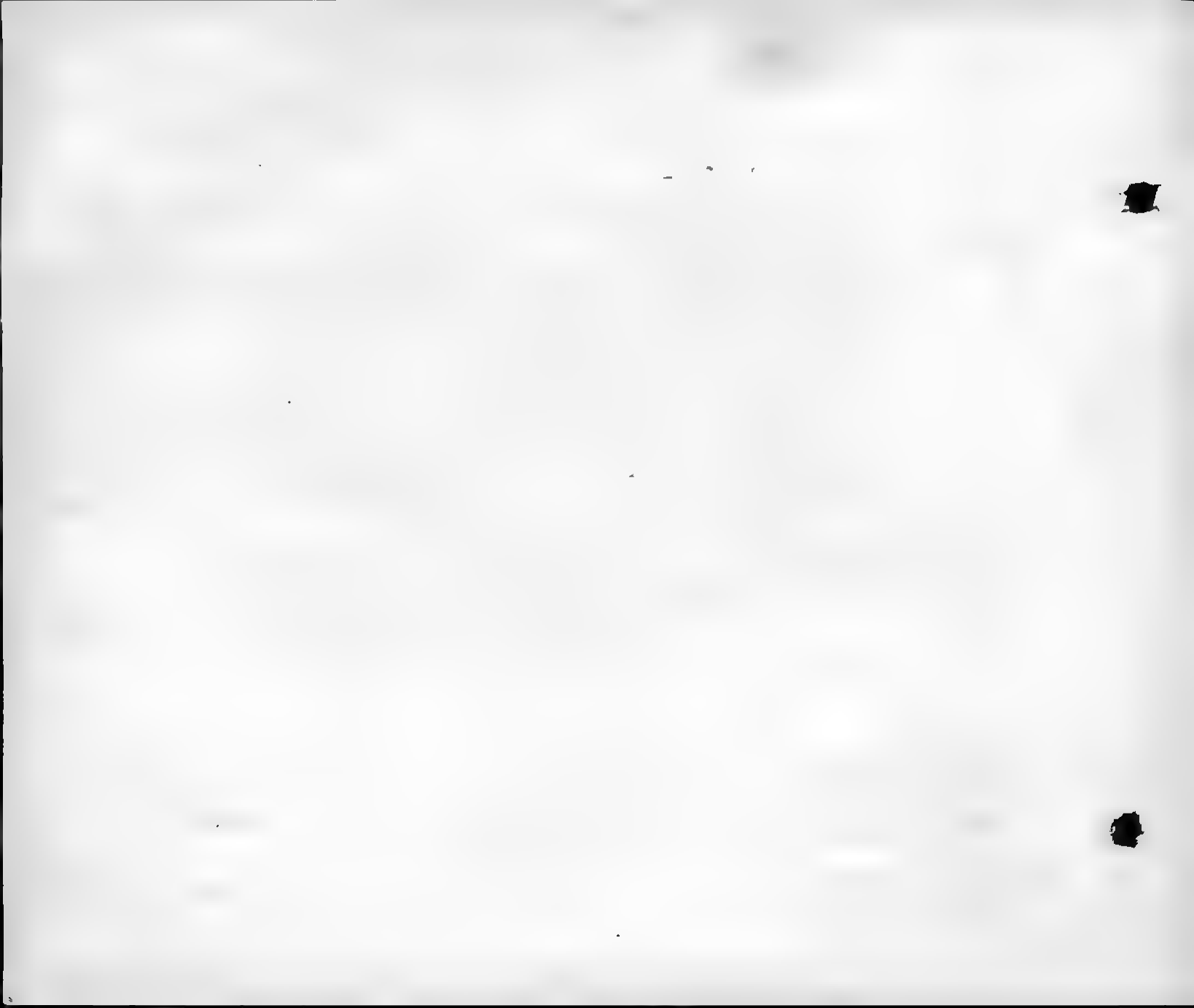
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL HOME OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10368 CERTIFICATE OF DEATH

10493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick Park</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington General Hospital</u>		d. STREET ADDRESS <u>7224 MINNER PLACE</u>	
3. NAME OF DECEASED (Type or print) <u>Glenn Thomas Stiles</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT</u>	9. AGE (In years last birthday) <u>55</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN STILES</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 1942-1945</u>		16. SOCIAL SECURITY NO. <u>2221</u>	
17. INFORMANT <u>Mrs Ruth Stiles</u>		Address <u>2221 Union St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE, SUBARACHNOID, BASILAR, MASSIVE - SUDDEN</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>11/17</u> 19 <u>59</u> , that I last saw the deceased alive on <u>7/17</u> 19 <u>59</u> , and that death occurred at <u>3:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Adrian H. Harding</u>		M.D. <u>113 Carroll St. in Wash DC 7/17/59</u>	
PHYSICIAN'S NAME (Type) <u>Adrian H. Harding</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept 22, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Patterson</u>		24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>	
ADDRESS <u>25A Carroll St. N.E.</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Fennell</u>	



10518

## CERTIFICATE OF DEATH

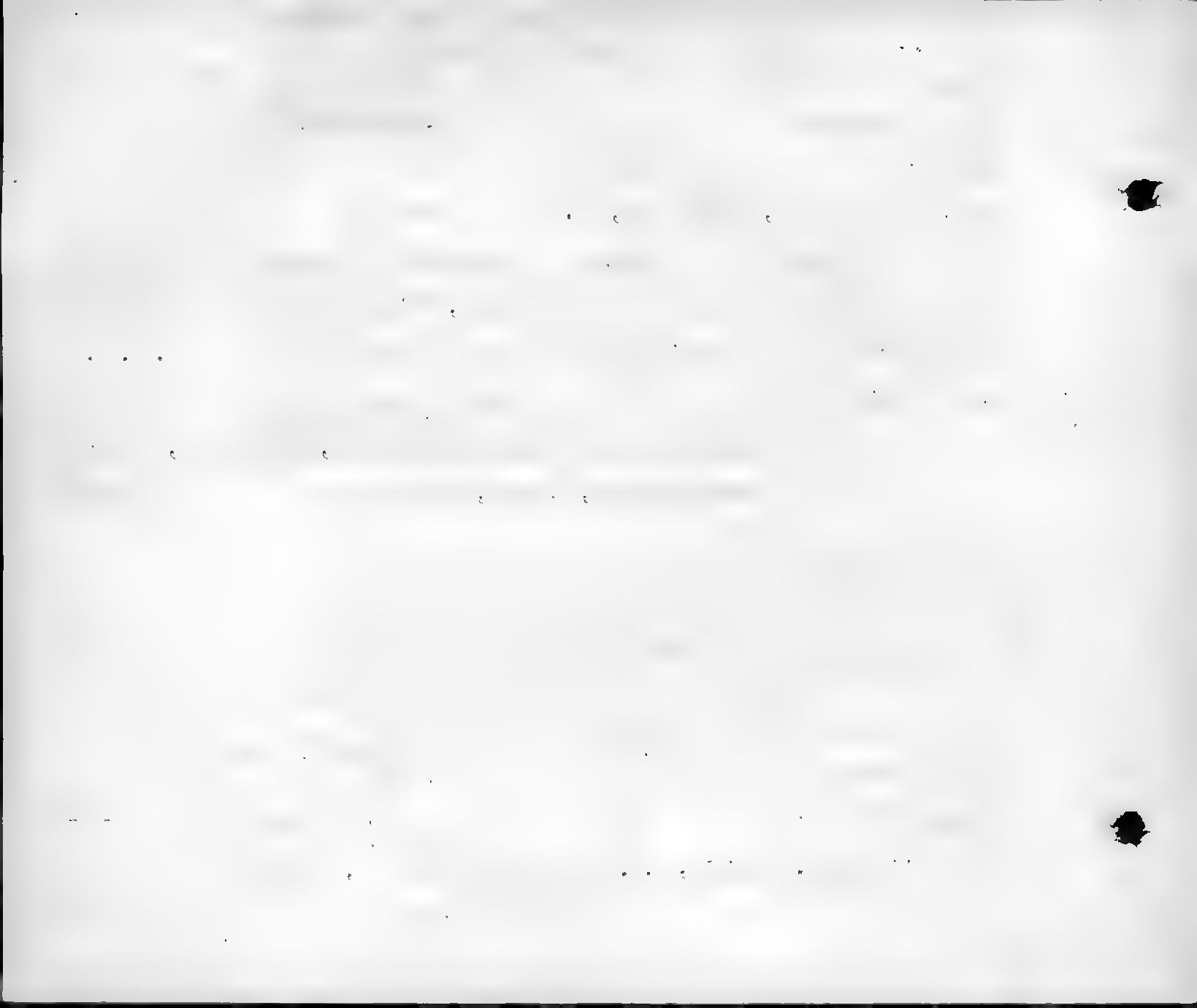
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Seneca</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY in 1b <b>71 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Christine</b> Middle <b>Mabell</b> Last <b>Swafford</b>				4. DATE OF DEATH Month <b>September</b> Day <b>27</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 3, 1929</b>	
9. AGE (In years last birthday) <b>30</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile Industry</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>George Collins</b>			
14. MOTHER'S MAIDEN NAME <b>Minnie Sloan</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>			
16. SOCIAL SECURITY NO <b>Unascertainable</b>				17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma, Primary, Left Lung</b> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>4 Months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 18</b> , 19 <b>59</b> , to <b>September 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>September 27</b> , 19 <b>59</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>9-28-59</b>							
ACTUAL SIGNATURE <b>Vincent T. Andriole</b> M.D.				PHYSICIAN'S NAME (Type) <b>Vincent T. Andriole, M.D.</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/30/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>O'Conner Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Seneca, S. Car.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b> ADDRESS <b>1400 Chapin St. NW Wash., D.C.</b>				24a. REC'D BY REGISTRAR <b>OCT 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kross</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10519

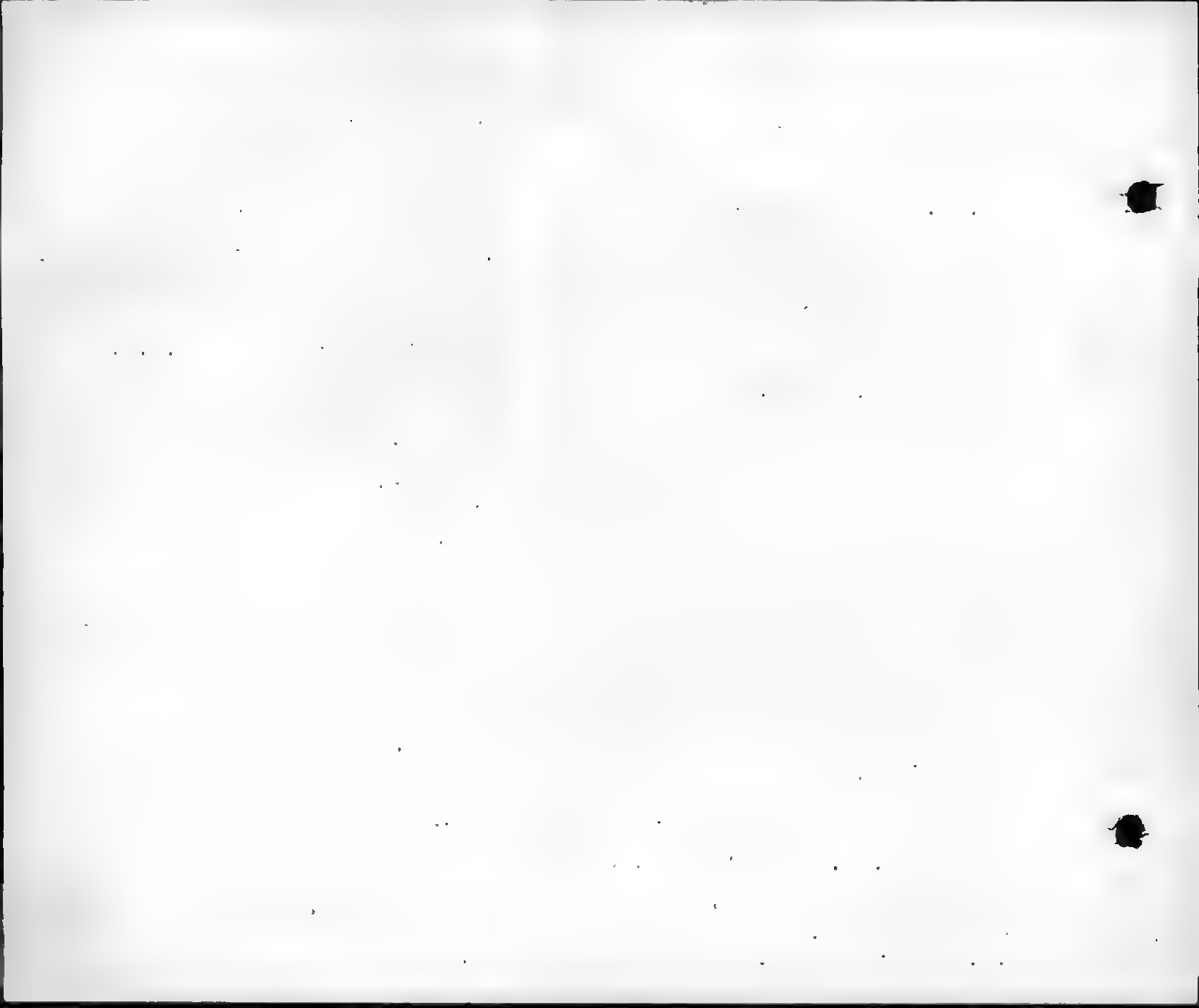
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>So. Carolina</b>		b. COUNTY <b>7</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>777 Laurel Bay Blvd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Donald</b>		Middle <b>Raymond</b>		Last <b>TERRELL</b>		4. DATE OF DEATH Month <b>September</b>		Day <b>3</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-8-54</b>		9. AGE (In years lost birthday) <b>5</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>		11. BIRTHPLACE (State or foreign country) <b>No. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Walter L. TERRELL</b>				14. MOTHER'S MAIDEN NAME <b>Monica PATTERSON</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>(F) Walter L. Terrell, same as #2 above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Post-operative cardiotomy</b> <b>Congenital Heart Disease</b> <b>(Tetralogy of Fallot)</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>Birth</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Indianapolis</b>		(County) (State)	
21. I certify that I attended the deceased from <b>August 24, 1959</b> to <b>September 3, 1959</b> , that I last saw the deceased alive on <b>Sept. 3, 1959</b> , and that death occurred at <b>1015A</b> AM, from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>C. A. Broaddus, Jr.</i>		M.D. <b>USN</b>		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>				DATE SIGNED <b>9-3-59</b>	
PHYSICIAN'S NAME (Type) <b>C. A. BROADDUS, Jr., CDR, MC</b>		<b>Bethesda, Maryland</b>							
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <b>Burial-Shipment 9-4-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) <b>Indianapolis</b>		(State) <b>Indiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i>		ADDRESS <b>R. A. Pumphrey Funeral Home, Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Charles E. K...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

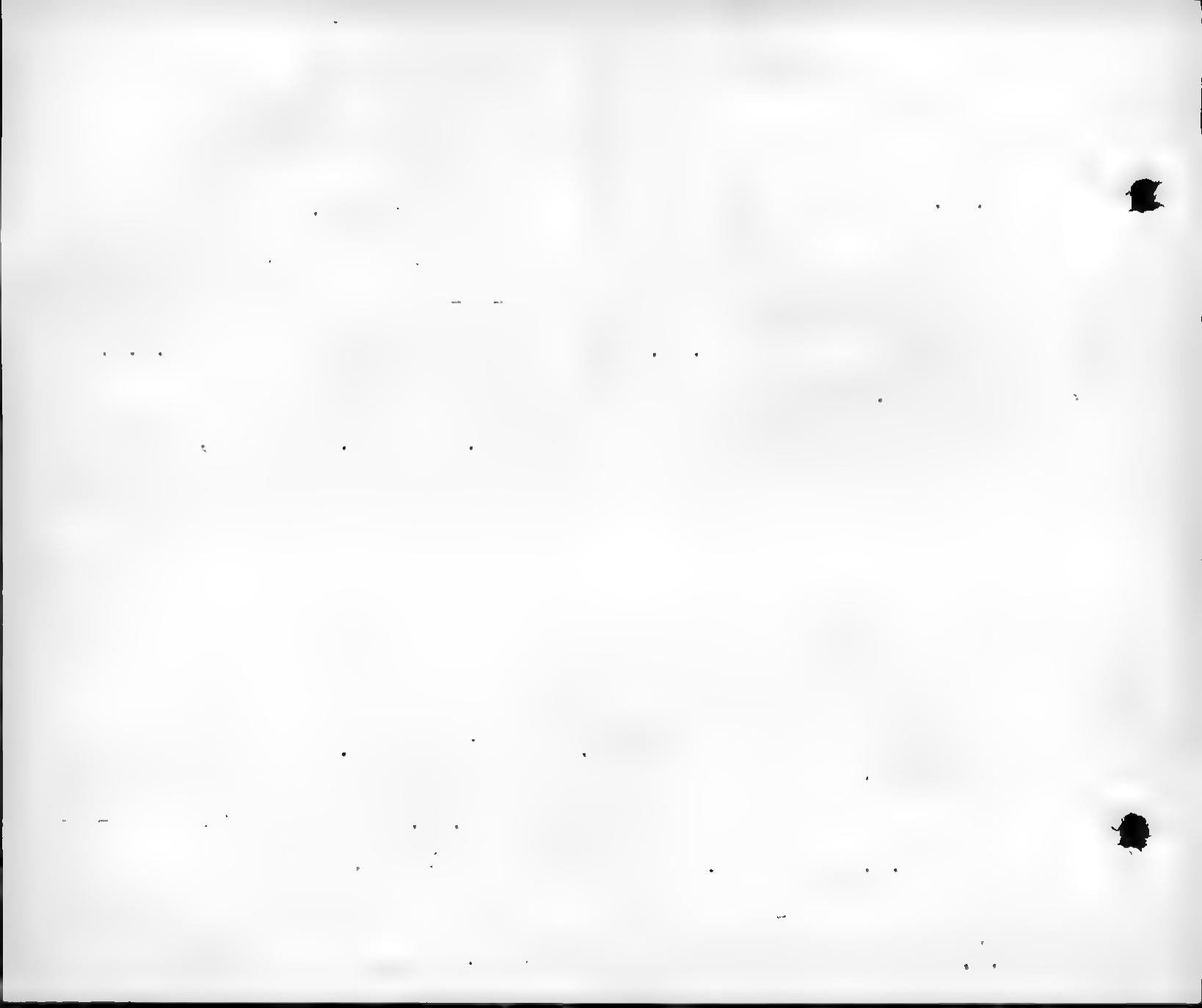
Reg. Dist. No. 215

10520

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Pinellas</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clearwater</b> d. STREET ADDRESS <b>608 Mariva Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louis Francis THIBAUT</b>				4. DATE OF DEATH Month Day Year <b>September 16 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-28-85</b>	
9. AGE (n years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>	
13. FATHER'S NAME <b>Nelson J. THIBAUT</b>				14. MOTHER'S MAIDEN NAME <b>Mary DEMPSEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO <b>WWI &amp; II</b>		INFORMANT Address <b>(W)Mrs. Hazel P. Thibault, same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, bronchogenic, with metastases</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 10</b> , 19 <b>59</b> to <b>Sept. 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 16</b> , 19 <b>59</b> , and that death occurred at <b>640P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital 9-17-59</b>							
ACTUAL SIGNATURE <b>F. J. Linehan, Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>F. J. LINEHAN, JR., LCDR, MC, USN Bethesda, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b> R. A. Pumphrey Funeral Home, Bethesda, Md.				24a. REC'D BY REGISTRAR DATE <b>SEP 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Kneass</b>	

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## CERTIFICATE OF DEATH

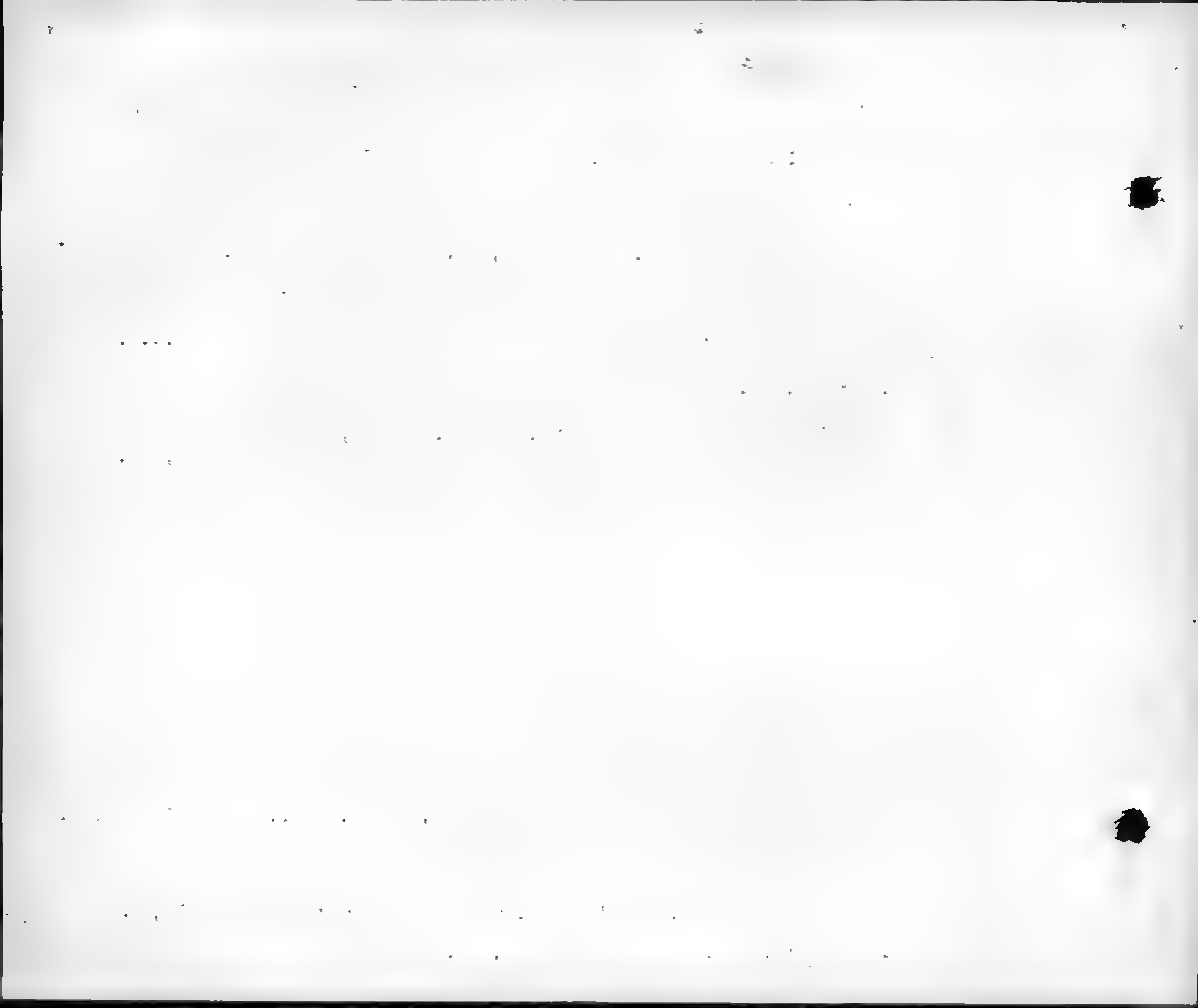
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c LENGTH OF STAY IN 1b <b>30 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9228 WOODLAND DRIVE</b>		e STREET ADDRESS <b>9228 WOODLAND DRIVE</b>	
3 NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>M.</b> Last <b>THOMAS, JR.</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>6</b> Year <b>19 59</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2/22/26</b>
9. AGE (In years last birthday) <b>33</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FOOD BROKERAGE FIRM</b>	
11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE M. THOMAS, SR.</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN SPENCER</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name known) <b>YES</b>		16. SOCIAL SECURITY NO <b>yes</b>	
17. INFORMANT <b>Mrs. Rita M. Thomas, 9228 Woodland Drive</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LARYNGEAL OBSTRUCTION</b> 474X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LARYNGITIS</b> DUE TO (c) <b>VIRUS INFECTION</b> INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>3 DAYS</b> <b>1 WEEK</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) <b>NONE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/31</b> , 19 <b>59</b> , to <b>9/5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9/5</b> , 19 <b>59</b> , and that death occurred at <b>4 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10,011 Ga. Ave., Silver Spring, Md.</b> DATE SIGNED <b>9/6/59</b>			
ACTUAL SIGNATURE <b>Henry W. Stout MD</b>		M.D. <b>10,011 Ga. Ave., Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>HENRY W. STOUT MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/9/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CATH. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>		ADDRESS <b>SILVER SPRING, MD</b>	
24a. REC'D BY REGISTRAR <b>SEP 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

NOT FOR NOTIFIED - RELEASED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10498

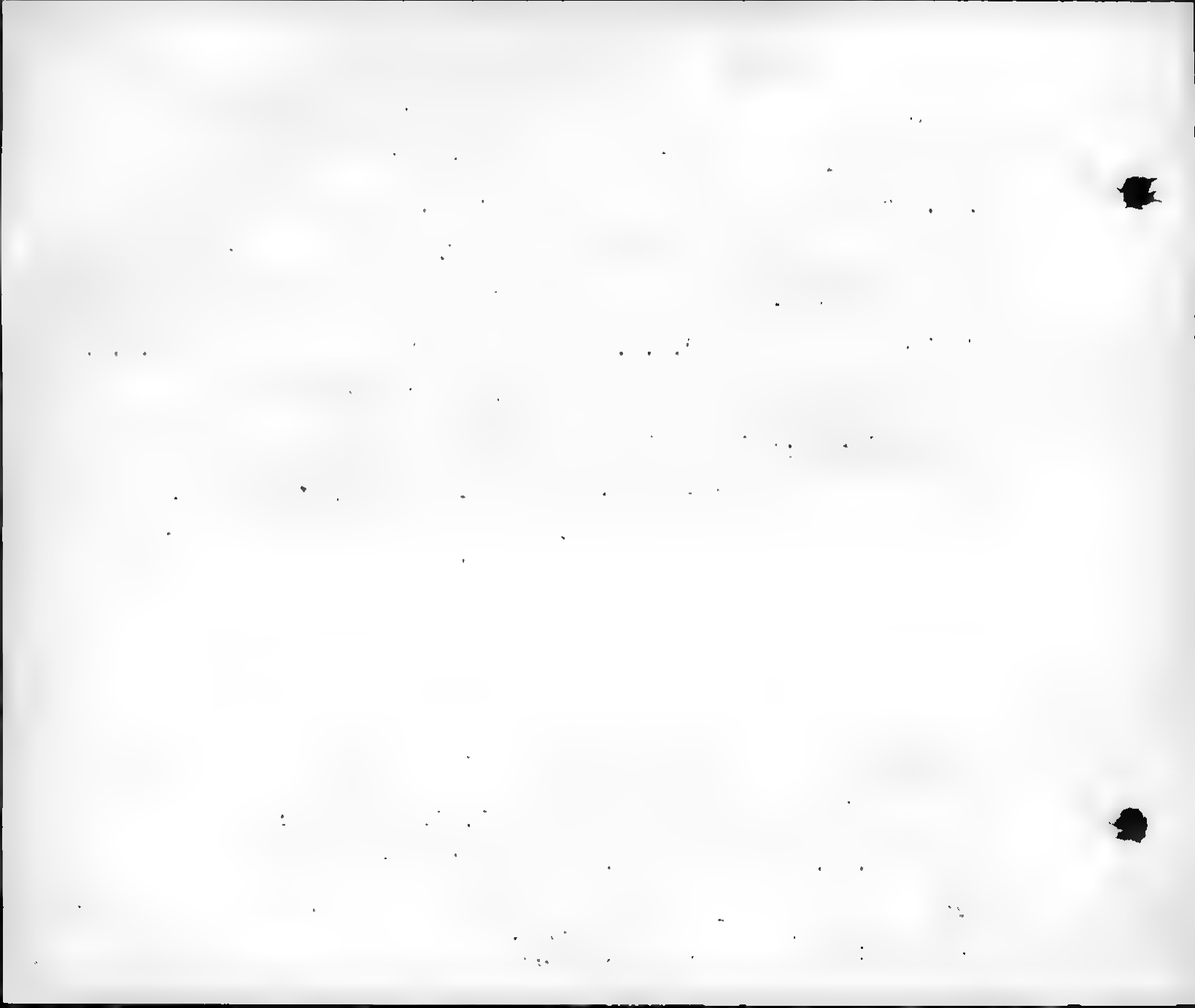
10522

CERTIFICATE OF DEATH

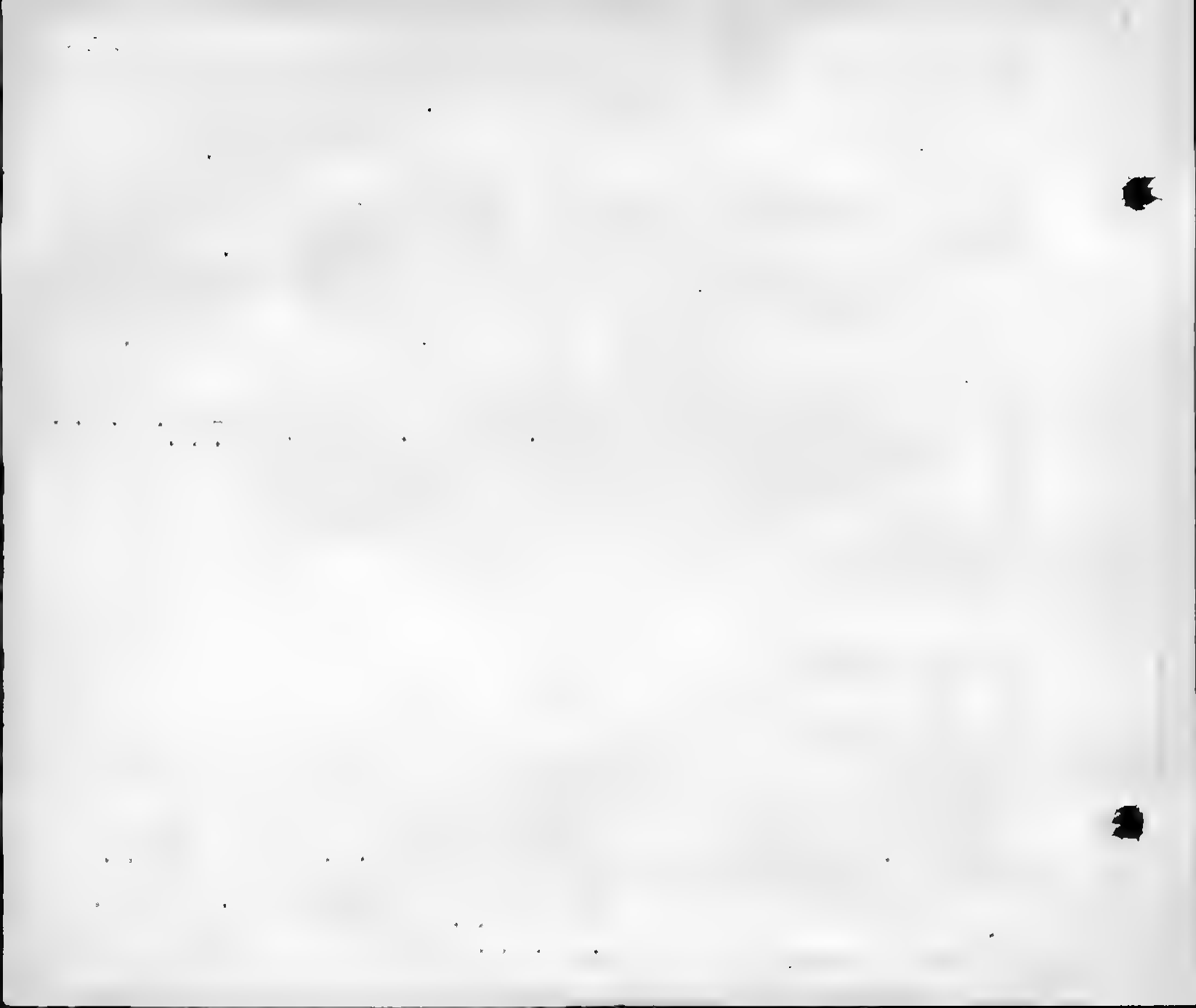
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>53 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>6581 N. 29th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Axel</b> Middle <b>Kolbjorn</b> Last <b>THOMPSON</b>		4. DATE OF DEATH Month <b>September</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-5-72</b>
9. AGE (In years last birthday) <b>86</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b> Hours <b>2</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.</b>	
11c. BIRTHPLACE (State or foreign country) <b>Norway</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andres Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Dorthea (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>Box Rep. SA Mexican War</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> (c) <b>Arteriosclerotic heart disease and debilitation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 11</b> , 19 <b>59</b> , to <b>Sept. 2</b> , 19 <b>59</b> and that death occurred at <b>8 P. M.</b> from the causes and on the date stated above. alive on <b>Sept. 2</b> , 19 <b>59</b> and that death occurred at <b>8 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>9-3-59</b>			
ACTUAL SIGNATURE <b>William P. Baker</b> M.D.		U. S. Naval Hospital	
PHYSICIAN'S NAME (Type) <b>W. P. BAKER, LT, MC, USN</b>		<b>Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-5-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home, Ath &amp; Mass. Ave. NW</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Carlton L. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







10523

## CERTIFICATE OF DEATH

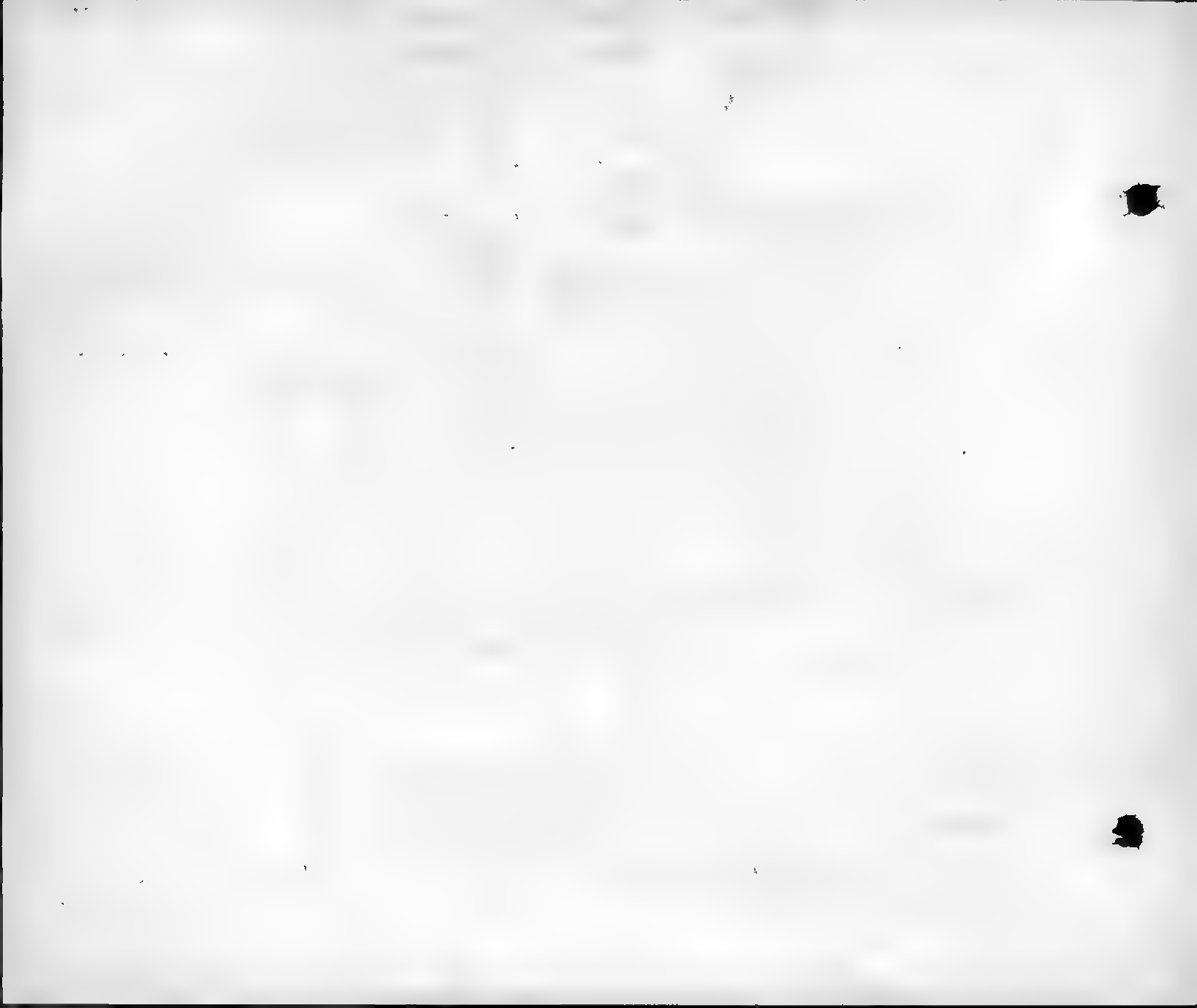
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Tabbs</b>		4. DATE OF DEATH Month Day Year <b>September 10 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-59</b>
9. AGE (In years last birthday) yrs <b>2</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours <b>2 25</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph L. Tibbs</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Grace Lambert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis of lungs</b> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity and Immaturity</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>4/10/1958</b> to <b>9/10/1959</b> , that I last saw the deceased alive on <b>9/10/1959</b> , and that death occurred at <b>3:32pm</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Sandy Spring, Maryland 9/10/59</b>			
ACTUAL SIGNATURE <b>J. W. Bird, M. D.</b>		PHYSICIAN'S NAME (Type) <b>Sandy Spring, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/11/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Germantown Baptist Ch</b>	22d. LOCATION (City, town, or county) (State) <b>Germantown, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur G. Fortin, Gaithersburg, Md</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur G. Fortin</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

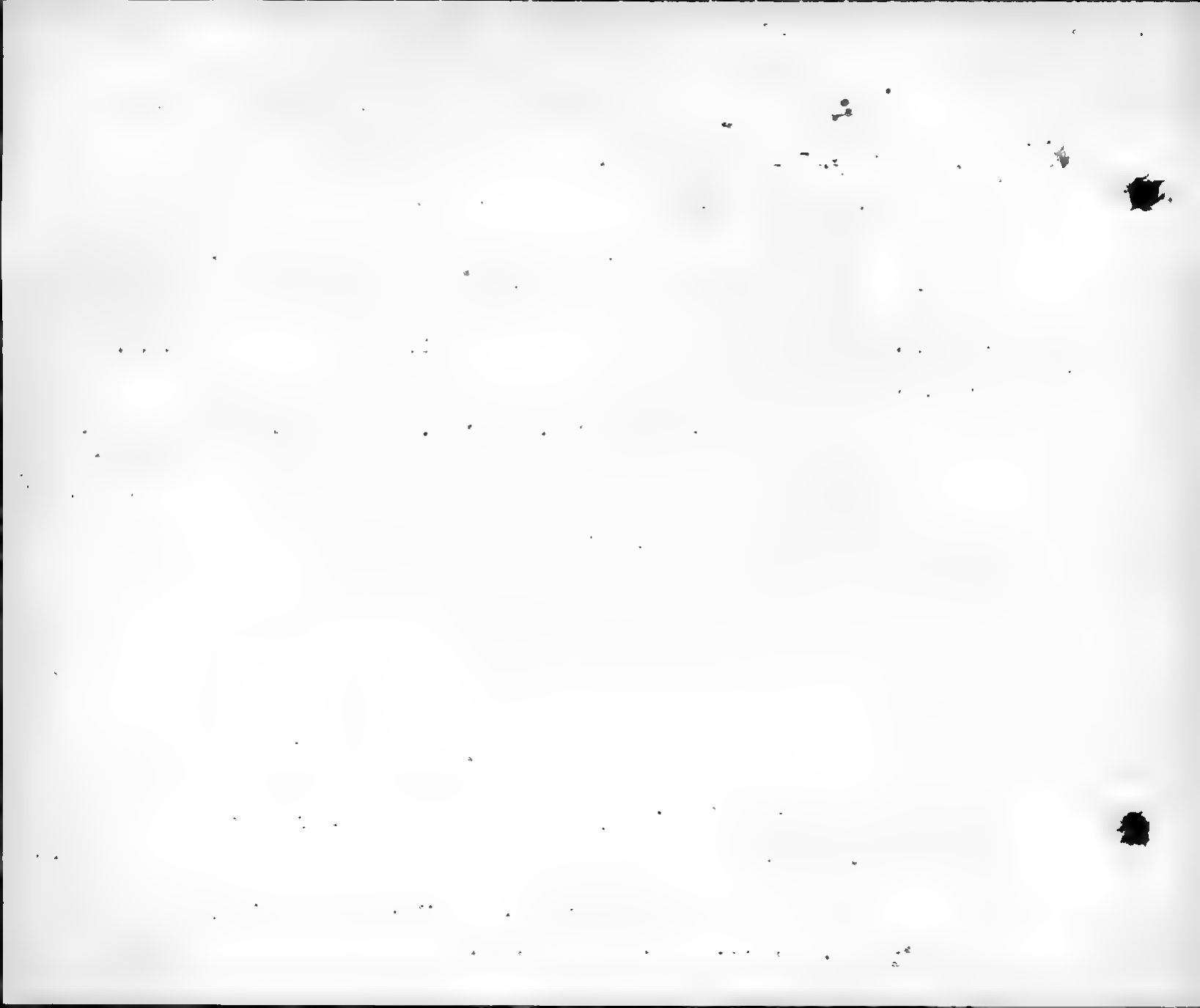
10501

10524

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>9 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>516 STONINGTON ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>MARIE</b> Last <b>TROUTNER</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/18/86</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Illinois</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>THOMAS BRYAN</b>	
14. MOTHER'S MAIDEN NAME <b>JOHANNA REITCHE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Eugene C. Spangler, 516 Stonington Rd. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Transition</b> 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of pancreas</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>2 yrs</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>59</b> , to <b>Sept 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 18</b> , 19 <b>59</b> , and that death occurred at <b>7:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Md.</b> DATE SIGNED <b>9/28/59</b> ACTUAL SIGNATURE <b>Donald Nelson</b> M.D. PHYSICIAN'S NAME (Type) <b>DONALD NELSON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Mem. Park Cemetery,</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



10525

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>29 days</b> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>477</b> d. STREET ADDRESS <b>1315 Pennsylvania S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>William Henry TURK</b>		4. DATE OF DEATH Month Day Year <b>September 24 1959</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7-15-86</b>
9 AGE (in years last birthday) <b>73 yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(U.S. Navy) Did not work after retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Michigan</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. C. TIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Allen TURK</b>		14. MOTHER'S MAIDEN NAME <b>Ada MATHEWS</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>		16 SOCIAL SECURITY NO <b>unknown</b>	
INFORMANT <b>(Wife) Cora Turk</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Squamous Cell Carcinoma of Esophagus</b> DUE TO (c) <b>1 year</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>26 August, 1959</b> to <b>24 Sept., 1959</b> , that I last saw the deceased alive on <b>24 September, 1959</b> , and that death occurred at <b>6:32 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Douglas R. Koth</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>	
PHYSICIAN'S NAME (Type) <b>Douglas R. KOTH LT MC USN</b>		<b>U.S. Naval Hospital, Bethesda Md.</b>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-28-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. CHAMBERS</b>		24a. REC'D BY REGISTRAR <b>SEP 30 1959</b>	
ADDRESS <b>517 11th St. S.E. Washington D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the office prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

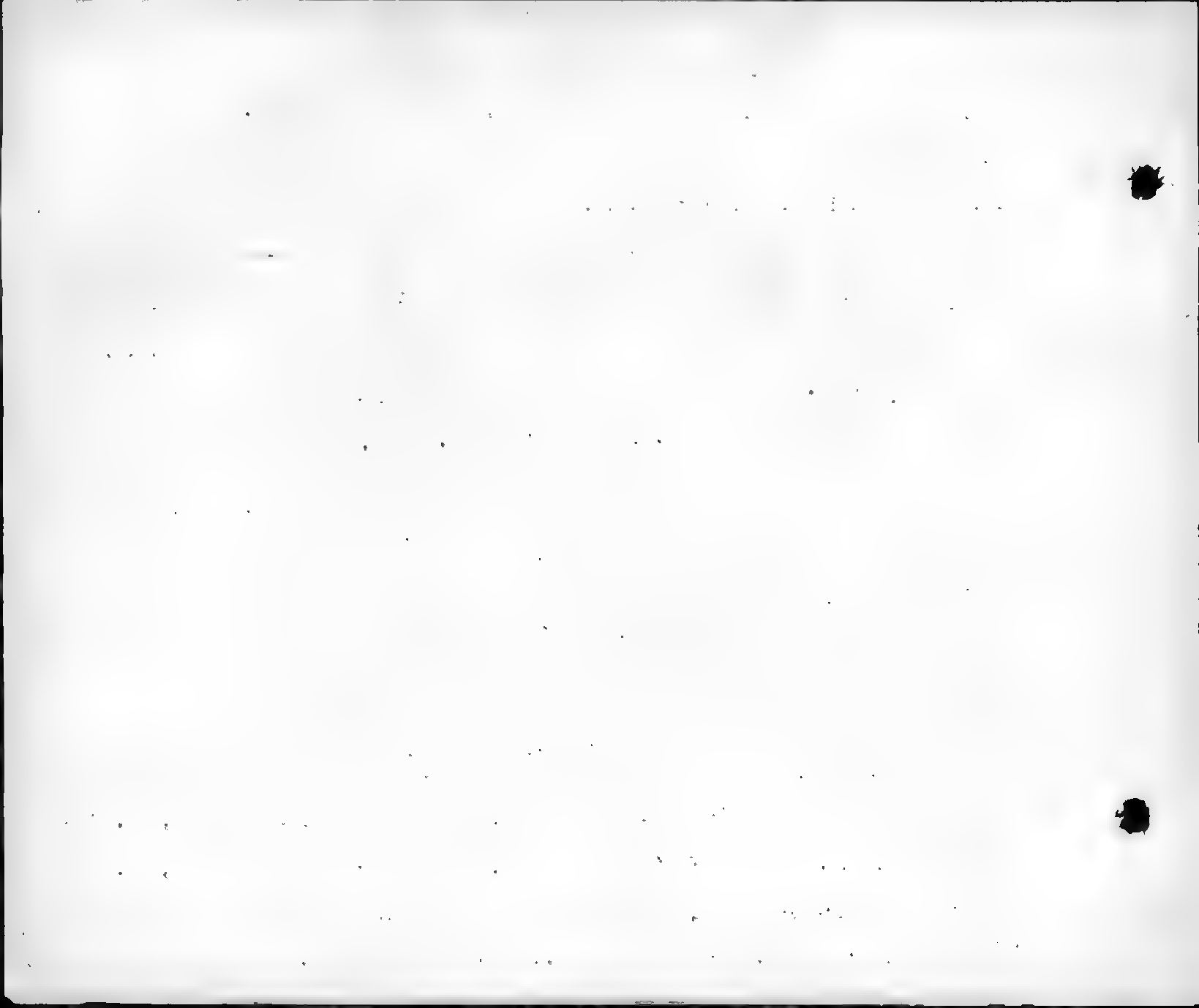
## 10526 CERTIFICATE OF DEATH

10503

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>10 hours</b> d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda 14, Md.</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Pa rk</b> d. STREET ADDRESS <b>645 Chinlee Drive</b> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Timothy Kevin VAUGHN</b>		4. DATE OF DEATH Month Day Year <b>September 5 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 19, 1959</b>
9. AGE (In years last birthday) <b>16</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>16</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George F. VAUGHAN</b>		14. MOTHER'S MAIDEN NAME <b>Lois CONTRELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(Father) George F. VAUGHAN (Same as #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>082.1</b> DUE TO <b>Heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Etiology undetermined</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aseptic meningitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 September 1959</b> to <b>5 September 1959</b> , that I last saw the deceased alive on <b>5 September 1959</b> , and that death occurred at <b>0:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 9-5-59</b>			
ACTUAL SIGNATURE <b>G. B. Avery</b>		M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>G. B. AVERY, LT MC USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-9-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington Virginia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PUMPHREY FUNERAL HOME, 8434 Georgia Ave., Silver Springs, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 5 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knapp</b>			

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10369

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10594

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosena</u> Middle <u>M</u> Last <u>Vincent</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1881</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph C. Duck</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Sauerswald</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Barbara M. Hanes</u>		Address <u>311 Boyd Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Atherosclerosis Generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u> <u>5 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>76</u> , to <u>20 Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19 Sept</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. B. Queen</u>		ADDRESS (Street, city or town, state) <u>7112 Willow Ave</u> DATE SIGNED <u>20 Sept</u>	
PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>		<u>Takoma Park, Md</u> <u>1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-23-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Sellers Sons Co</u>		ADDRESS <u>3605-14 St W</u>	
24a. REC'D BY REGISTRAR <u>SEP 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William G. Hanes</u>	





10370

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If inst-t on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakama Park</u>		c. LENGTH OF STAY IN 1b <u>W. Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>8118 - 14th Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM FRANCIS Vollmer</u>		4. DATE OF DEATH Month Day Year <u>9 19 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-59</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min <u>1 14 15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Sakama Park, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William F. Vollmer</u>		14. MOTHER'S MAIDEN NAME <u>Annette Xavese Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ANOXIA</u> <u>762.0</u> DUE TO <u>undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>undetermined</u> (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R Coleman MD</u> M.D.		ADDRESS (Street, city or town, state) <u>733 SLIGO AVE. SILVER SPRING, MD.</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R COLEMAN</u>		DATE SIGNED <u>9/20/59.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Co</u> ADDRESS <u>Riversdale Md</u>		24a. REC'D BY REGISTRAR <u>SEP 22 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur B. James</u>	

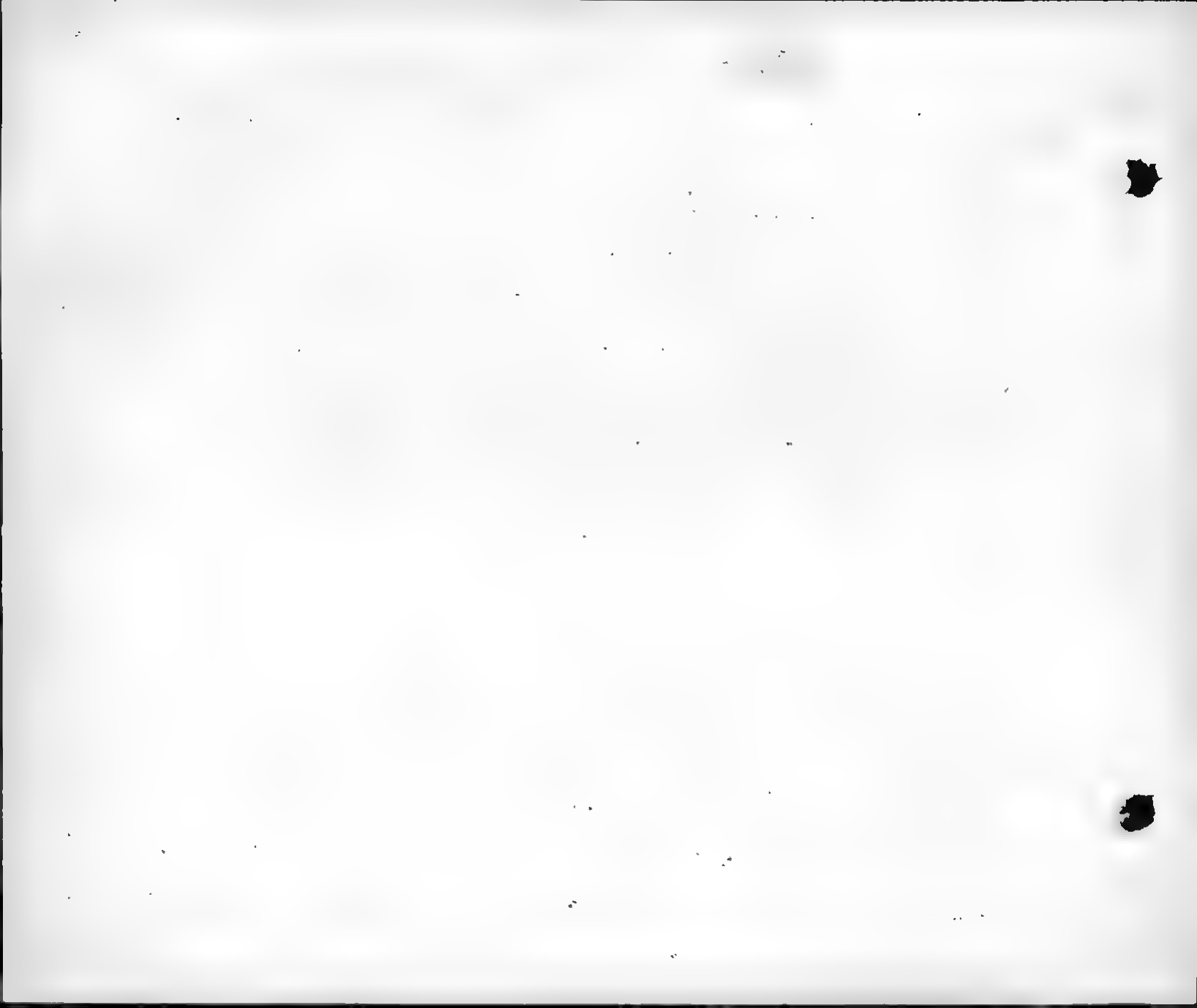
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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10527

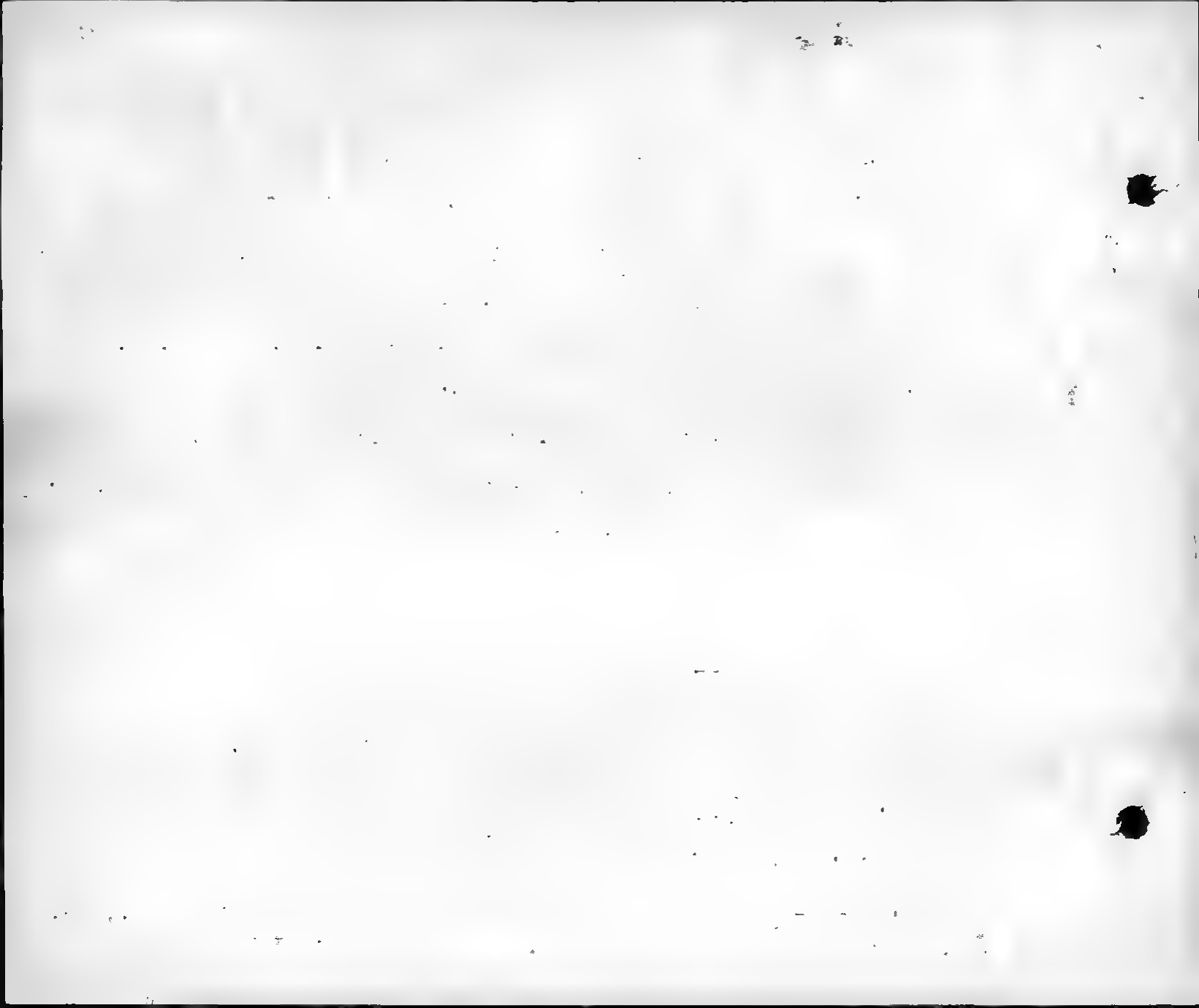
CERTIFICATE OF DEATH

10506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		2. USUAL RESIDENCE (Where deceased lived. If institut on Res dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6000 Springfield Drive</b>		e. STREET ADDRESS <b>6000 Springfield Drive</b> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ISABEL</b> Middle <b>GRAFF</b> Last <b>WALTEN</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>26,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1879</b>
9. AGE (In years last birthday) <b>79</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>12</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Charles Graff</b>	
14. MOTHER'S MAIDEN NAME <b>Antonie Beneke</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Son</b> Address <b>Dr. Maxmilian G. Walten Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO <b>&amp; Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 days</b> (c) <b>12 days</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/18</b> , 19 <b>55</b> , to <b>Sept 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 26</b> , 19 <b>59</b> , and that death occurred at <b>10 A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4630 Montgomery Ave., Bethesda, Maryland</b> DATE SIGNED <b>9-26-59</b>			
ACTUAL SIGNATURE <b>A. J. Brennan</b>		PHYSICIAN'S NAME (Type) <b>ANDREW J. BRENNAN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>9-29-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George Co., Md.</b>
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b> ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician and completely filled in by the funeral director, or it may be retained by the funeral director and completely filled in by the attending physician. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10371

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MONTGOMERY</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Wood</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-96</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>George Wood</u>			
14. MOTHER'S MAIDEN NAME <u>Mamie Bigley</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Parents Chart</u> Address <u>337 Kensington</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Coronary block in with myocardial infarction</u> DUE TO (b) <u>Anterior wall H. inf. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>174 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus &amp; chronic</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Sept 23, 1959</u> to <u>Sept 23, 1959</u> , that I last saw the deceased alive on <u>Sept 23, 1959</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D. <u>8501 Glenville Road</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>7/13/59</u>			
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>9/26/59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Hammerhead Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>Pittsburgh Pa.</u>				23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
24a. REC'D BY REGISTRAR <u>SEP 25 59</u>				24b. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10508

Reg. Dist. No.

10525

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> <span style="float: right;">b. COUNTY <u>✓</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN TB <u>4 HOURS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>APT. 124</u> <u>2711 GEORGIA AVE NW</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>SAVANNAH</u> Middle <u>WELBORN</u> Last <u>WELBORN</u>				<b>4. DATE OF DEATH</b> Month <u>9</u> Day <u>17</u> Year <u>1959</u>			
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>NEGRO</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>12/25 1900</u>		<b>9. AGE</b> (In years last birthday) <u>58</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>MAID</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOUSEKEEPING</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>NORTH CAROLINA</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>SOLOMON WELBORN</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>? CRAY</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <u>DIANE WELBORN</u>		Address <u>1300 ...</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Extracerebral hemorrhage</u> (b) <u>Cerebral Arteriosclerosis</u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u>		<b>(County)</b> <u>  </u>		<b>(State)</b> <u>  </u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> , <b>Inspection</b> <input type="checkbox"/> , <b>Inquiry</b> <input type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u> <span style="float: right;">M.D.</span>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>9-18-59</u>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Brosch</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>  </u>		<b>22b. DATE THEREOF</b> <u>9-21-1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Lincoln Mem</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Suitland Rd</u>		<b>(State)</b> <u>MD</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Henry S. Washington</u>			
<b>ADDRESS</b> <u>467 N 27th NW</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>SEP 22 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. ...</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10509

Reg. Dist. No.

10529

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>DCA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seawood Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>1809 Pine Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Sydney</u> Middle <u>H.</u> Last <u>Wentworth</u> <b>4. DATE OF DEATH</b> Month <u>9</u> Day <u>17</u> Year <u>1959</u>				<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>W.</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec. 23, 1906</u> <b>9. AGE</b> (In years last birthday) <u>52</u> yrs. <b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Surgeon</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____ <b>11. BIRTHPLACE</b> (State or foreign country) <u>New York</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Louis Wentworth</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Harvey</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>092-09-427</u> <b>17. INFORMANT</b> <u>Wentworth - Wife - Same</u> Address _____			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour _____ a. m. _____ p. m. _____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschert</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>9-17-59</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>Sept. 20, 1959</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Andrew Chapel</u> <b>22d. LOCATION (City, town, or county)</b> <u>Malin, Virginia</u> (State) _____		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Everly Funeral Home</u> By <u>Manager</u> <b>ADDRESS</b> <u>Fairfax, Va.</u> <b>24a. REC'D BY REGISTRAR</b> <u>SEP 21 '59</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Frank</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

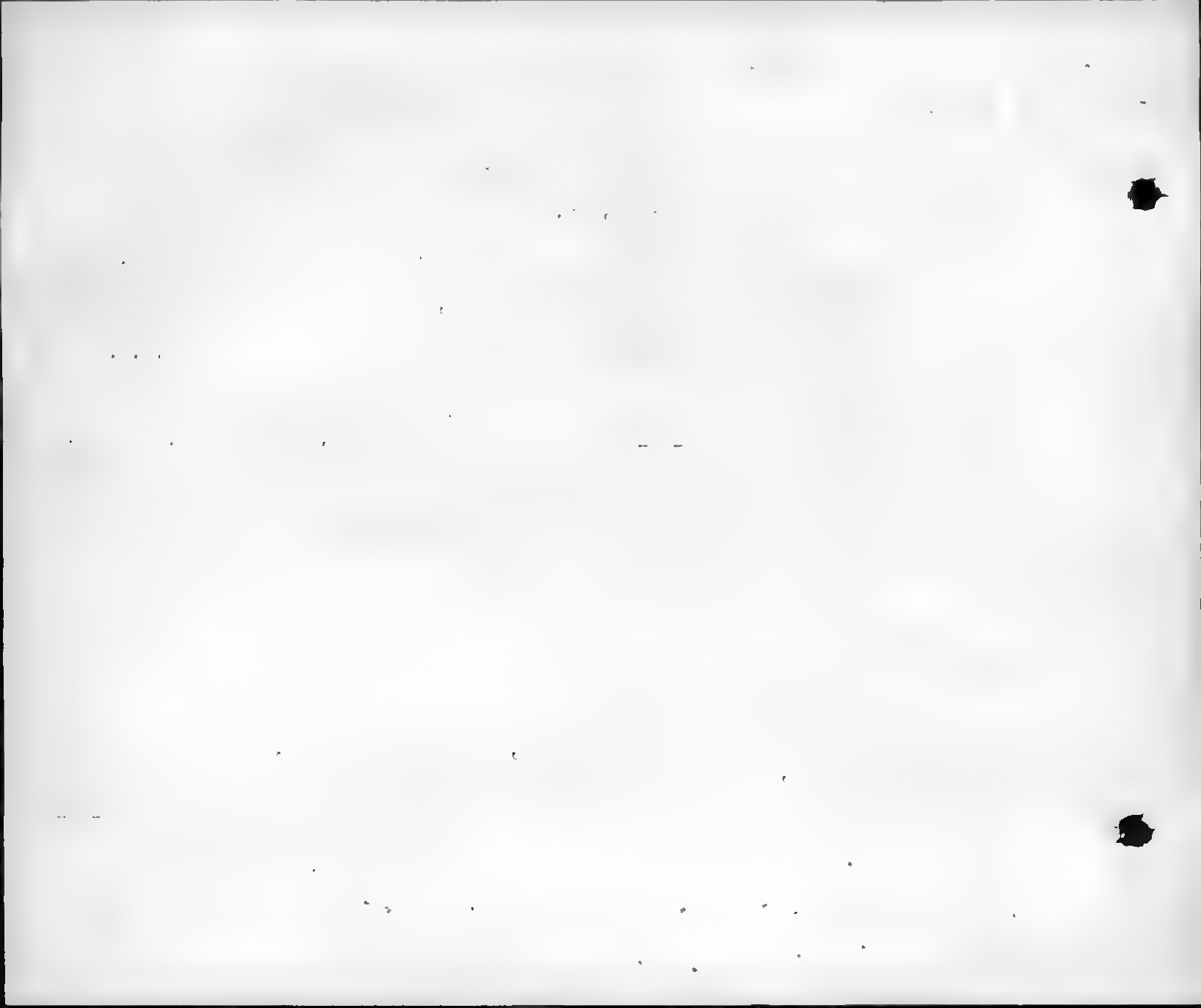


10530

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Sidman</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Box 9</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ned</b> Middle <b>(none)</b> Last <b>Westover</b>		4. DATE OF DEATH Month <b>September</b> Day <b>15</b> Year <b>19 59</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 21, 1896</b>	9. AGE (In years lost birthday) <b>63</b> yrs.	10. IF UNDER 1 YEAR Months <b>63</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic &amp; Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Edwin Westover</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Thompson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>208-07-0097</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Operative cardiac arrest</b> <b>421.1</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acquired calcific aortic stenosis</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>20 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town)</b> (County) (State)			
21. I certify that I attended the deceased from <b>September 6, 1959</b> to <b>September 15, 1959</b> , that I last saw the deceased alive on <b>September 15, 1959</b> , and that death occurred <b>11:05 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b> DATE SIGNED <b>9-15-59</b>							
ACTUAL SIGNATURE <i>E. Kent Carney</i> PHYSICIAN'S NAME (Type) <b>E. Kent Carney, M.D.</b>		M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FOREST-LAWN Cem.</b>			
22d. LOCATION (City, town or county) <b>JOHANSTOWN</b>		(State) <b>PA.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 17 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Kneale</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10531

CERTIFICATE OF DEATH

10511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <u>OakCrest Trailer Court</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OakCrest Germantown Md.</u>		c. LENGTH OF STAY IN 1b <u>12 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>KATHERINE</u> Last <u>WILLIAMS</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Darlington Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>George Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Katherine Beathley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Roy P. Williams</u>		Address <u>Germantown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Arteriosclerosis</u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, Severe</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 July</u> , 19 <u>59</u> , to <u>14 Sept.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>14 Sept.</u> , 19 <u>59</u> , and that death occurred at <u>5:5 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon M. Smith</u> M.D.		DATE SIGNED <u>14 Sept '59</u>	
PHYSICIAN'S NAME (Type) <u>Gordon M. Smith Md.</u>		<u>Barnesville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dail</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '59</u>	
ADDRESS <u>Frederick, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION



10532  
CERTIFICATE OF DEATH

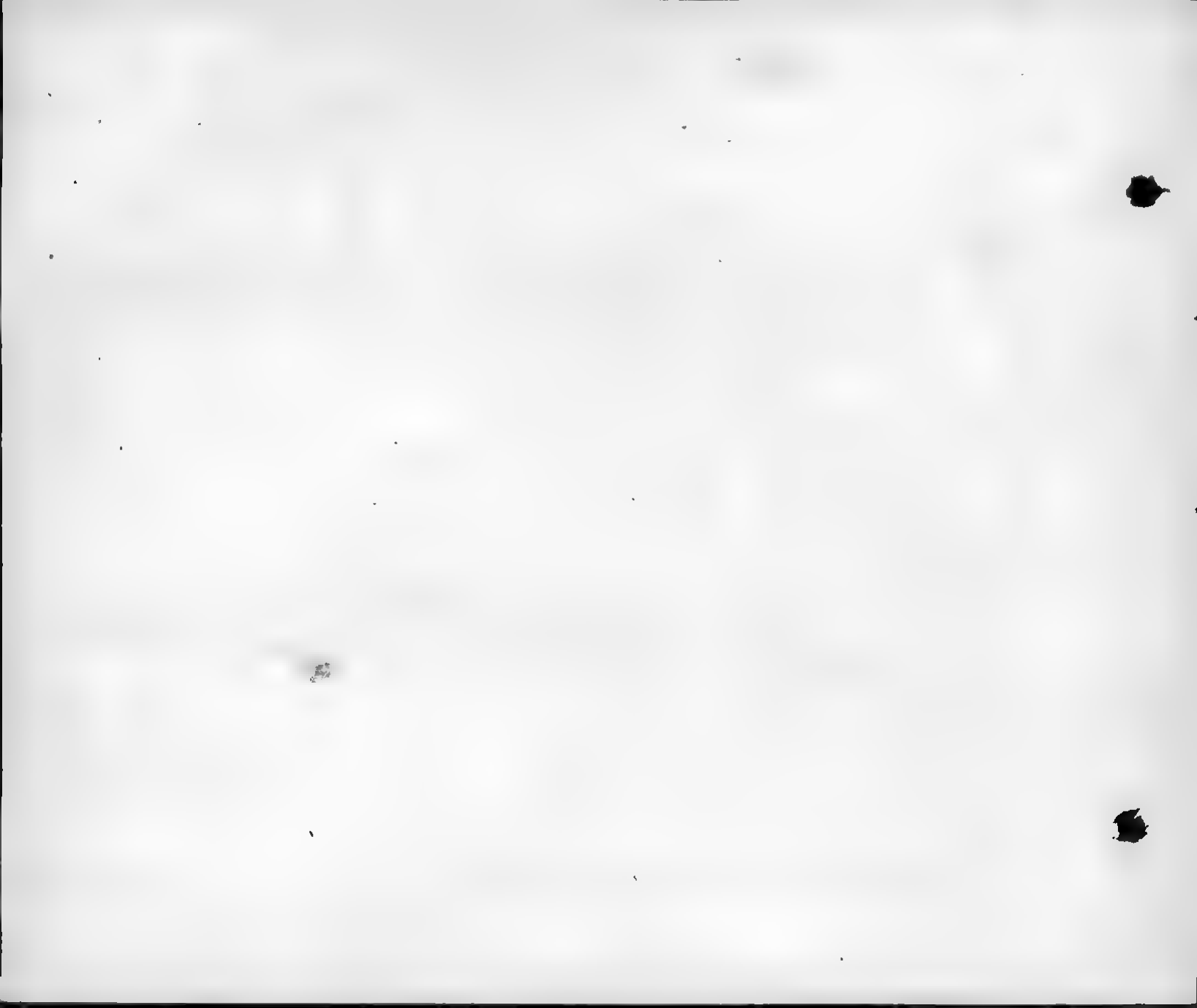
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>6 Hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Kenneth Edward Wilson</b>		4. DATE OF DEATH Month <b>9</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/23/59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Grace Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mary Grace Wilson</b>		Address <b>Woodstock, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Marasmus</b> <b>773.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Premature infant (4½ lbs at birth)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-23-</b> <b>19 59</b> , to <b>9-6-</b> <b>19 59</b> , that I last saw the deceased alive on <b>9-5-</b> <b>19 59</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Clarksville, Maryland</b> DATE SIGNED <b>9-7-59</b>			
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>		M.D. <b>Clarksville, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>9-7-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Albans</b>	22d. LOCATION (City, town, or county) (State) <b>Woodstock, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. H. Haight + Clarksville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 9 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





10533

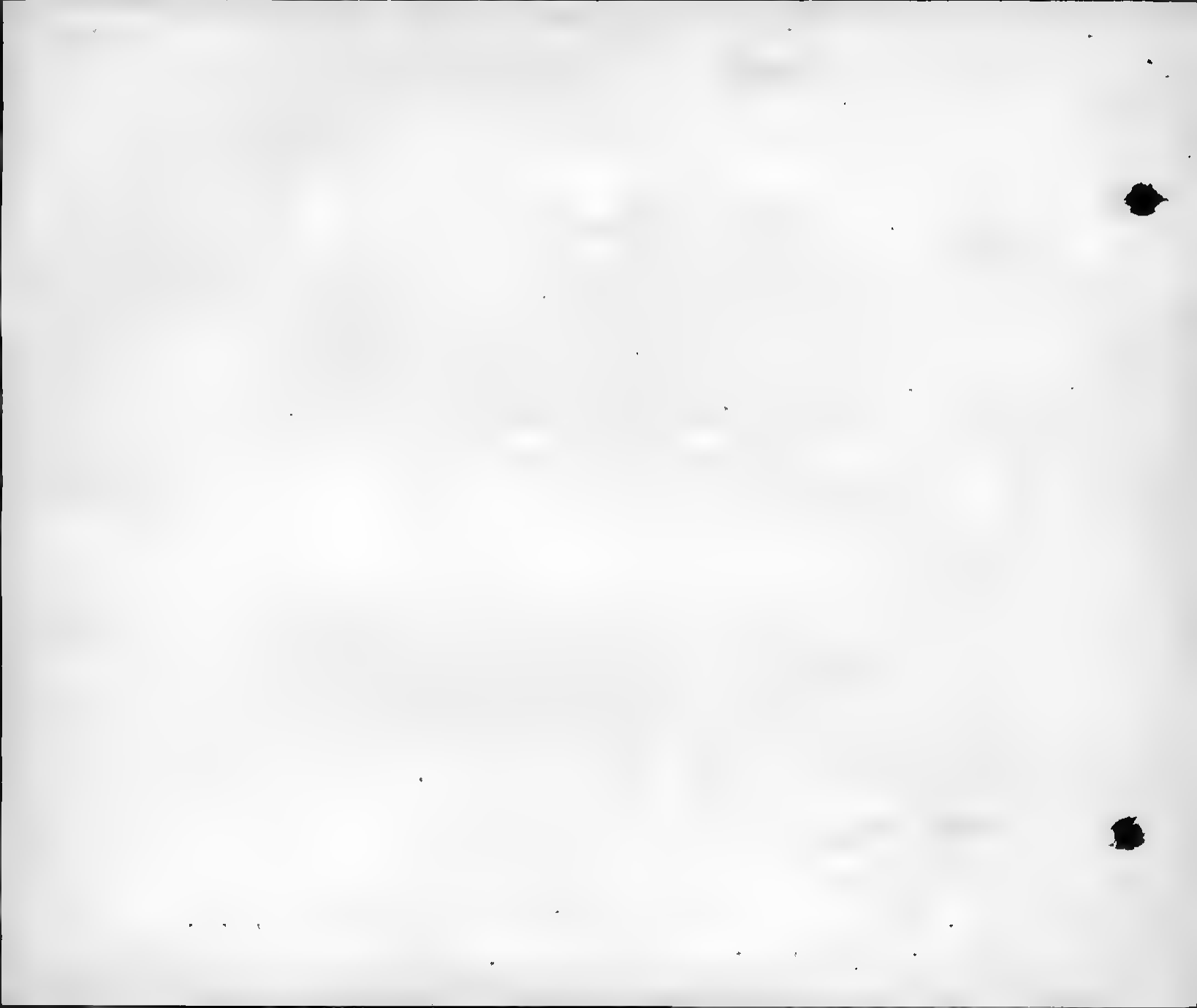
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>2mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. 21-DC.</u> <u>16x 2.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>6317 Walnut Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pearl</u> First <u>Hattie</u> Middle <u>Wilson</u> Last		4. DATE OF DEATH <u>Sept.</u> Month <u>1</u> Day <u>1959</u> Year					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27-1889</u>	9. AGE (In years, last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR, IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Taylorsville - N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Albert E. Chapman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pouey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</u> <u>5 yr</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-7-</u> 19 <u>59</u> , to <u>9-1-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>8-31-</u> 19 <u>59</u> , and that death occurred at <u>4-30</u> A.M. from the causes and on the date stated above							
ACTUAL SIGNATURE <u>J. W. Bond</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Sept 9/1/59</u>			
PHYSICIAN'S NAME (Type) <u>J. W. Bond</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. &amp; BURIAL 9/4/59</u>		<u>9/4/59</u>		<u>LONGVIEW CEMETERY</u>		<u>TAYLORSVILLE, N. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond R. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 3 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 10372 CERTIFICATE OF DEATH

Item 1 Film G248 9-11-59 et

Reg. Dist. No. ....

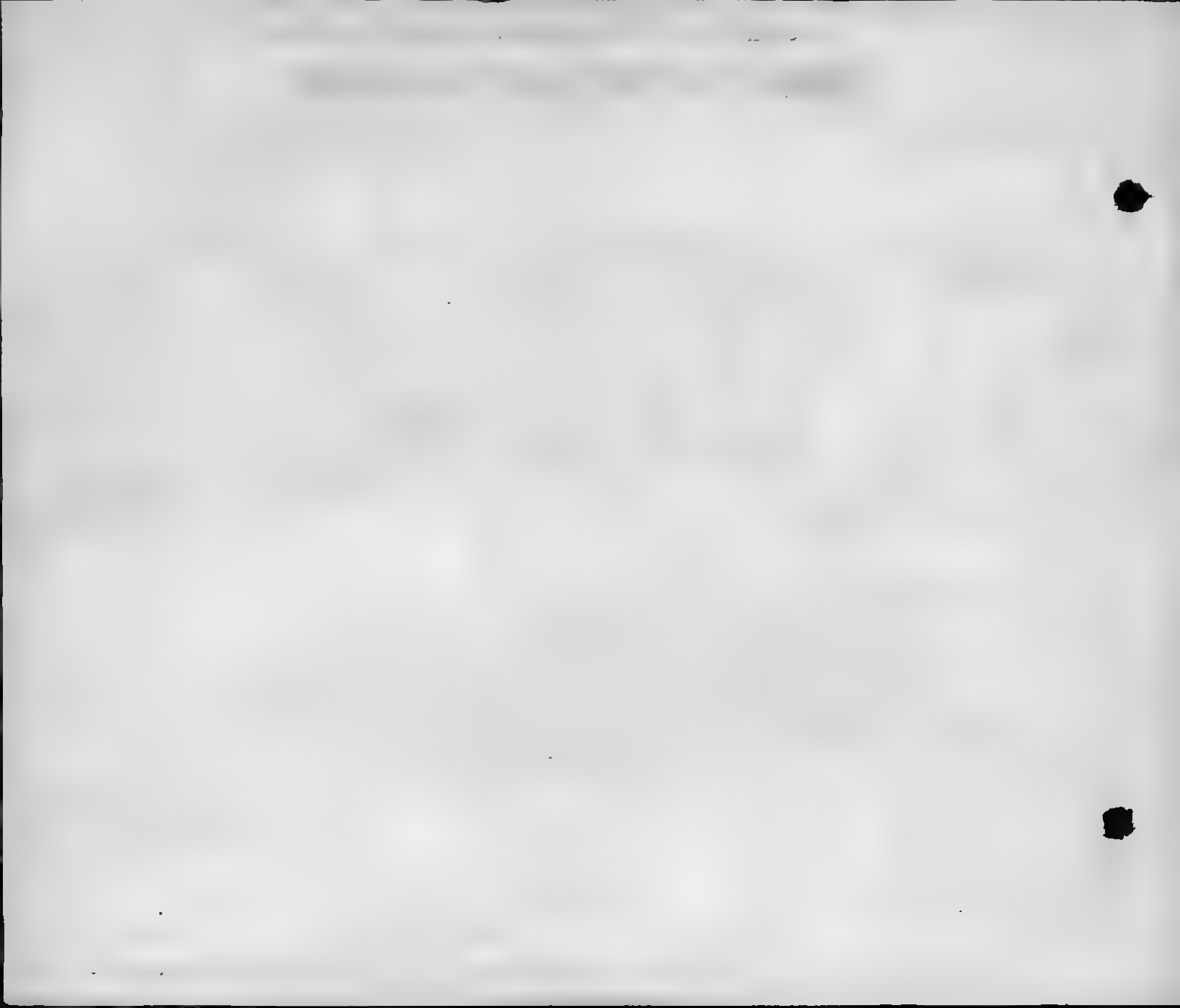
1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Dist. of Columbia</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR end give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
TOWN <u>Takoma Park 3 mo.</u>		TOWN <u>Washington 20 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>17300 Baltimore Avenue</u>		<u>1541 25th St. S.E.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>Myrtle Maryrbe WOCKLEY</u>		<u>Sept. 6, 19 59</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>December 17, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Housewife</u>		<u>Home</u>	<u>Washington, D.C.</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Dennis Callahan</u>		<u>Malvina Russell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
<u>No</u>		<u>No</u>	<u>Mrs. Anna Snider, 1609 3rd St. N.E., Wash. D.C.</u>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <input checked="" type="checkbox"/> <u>Arteriosclerosis, generalized</u>			<u>2 1/2 yrs.</u>
ANTECEDENT CAUSE(S) DUE TO <input checked="" type="checkbox"/> <u>Cerebral Thrombosis &amp; Paralysis</u>			<u>1 mo.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <input checked="" type="checkbox"/> <u>Cardiac Decompensation</u>			<u>1 WK.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Feb. 2, 19 59</u> , to <u>Sept. 6, 19 59</u> , that I last saw the deceased alive on <u>Sept. 3, 19 59</u> , and that death occurred at <u>3:35 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Lee Funeral Home</u>		ADDRESS (Street, city, town, state) DATE SIGNED <u>9-6-59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Arlington National</u>	
DATE THEREOF <u>9-10-59</u>		LOCATION (City, town, or county) (State)	
		<u>Ft Myer, Va.</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
SEP 8 '59		Lee Funeral Home - Wash. D.C.	
DATE		ADDRESS	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10534

## CERTIFICATE OF DEATH

10515

Reg. Dist. No.

Item 8 Film G248 9-17-59 et

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN IB <u>4 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x-3</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>				d. STREET ADDRESS <u>2728 Main St N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>GERTRUDE (NMI) WOOD</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>9 - 10 1959</u>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1861</u> <u>8-7-1861</u>	
<b>9. AGE</b> (In years last birthday) <u>78</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Fire Clerk</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Virginia Geographic</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Wash. D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>William A. Wood</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY A. BARRETT</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>NO</u>		<b>17. INFORMANT</b> Address <u>Hospital Records</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTHROSCLECTROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)				<b>21. I certify that I attended the deceased from</b> <u>APRIL 1959</u> to <u>SEPTEMBER 1959</u> that I last saw the deceased alive on <u>JULY 2, 1959</u> and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>Andrew E. Rudnai</u> M.D.				<b>ADDRESS</b> (Street, city or town, state) <u>5720 MacArthur Blvd. Washington DC</u>			
<b>PHYSICIAN'S NAME</b> (Type) <u>ANDREW E. RUDNAI</u>				<b>DATE SIGNED</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>12 Sept 59</u>		<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenwood Cem.</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Wash. D.C.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee Funeral Home</u> ADDRESS <u>44 MacArthur NE DC</u>				<b>24a. REC'D BY REGISTRAR</b> <u>work</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Orin &amp; Haines</u>	
<b>DATE</b> <u>SEP 15 '59</u>				<b>DATE</b> <u>SEP 15 '59</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

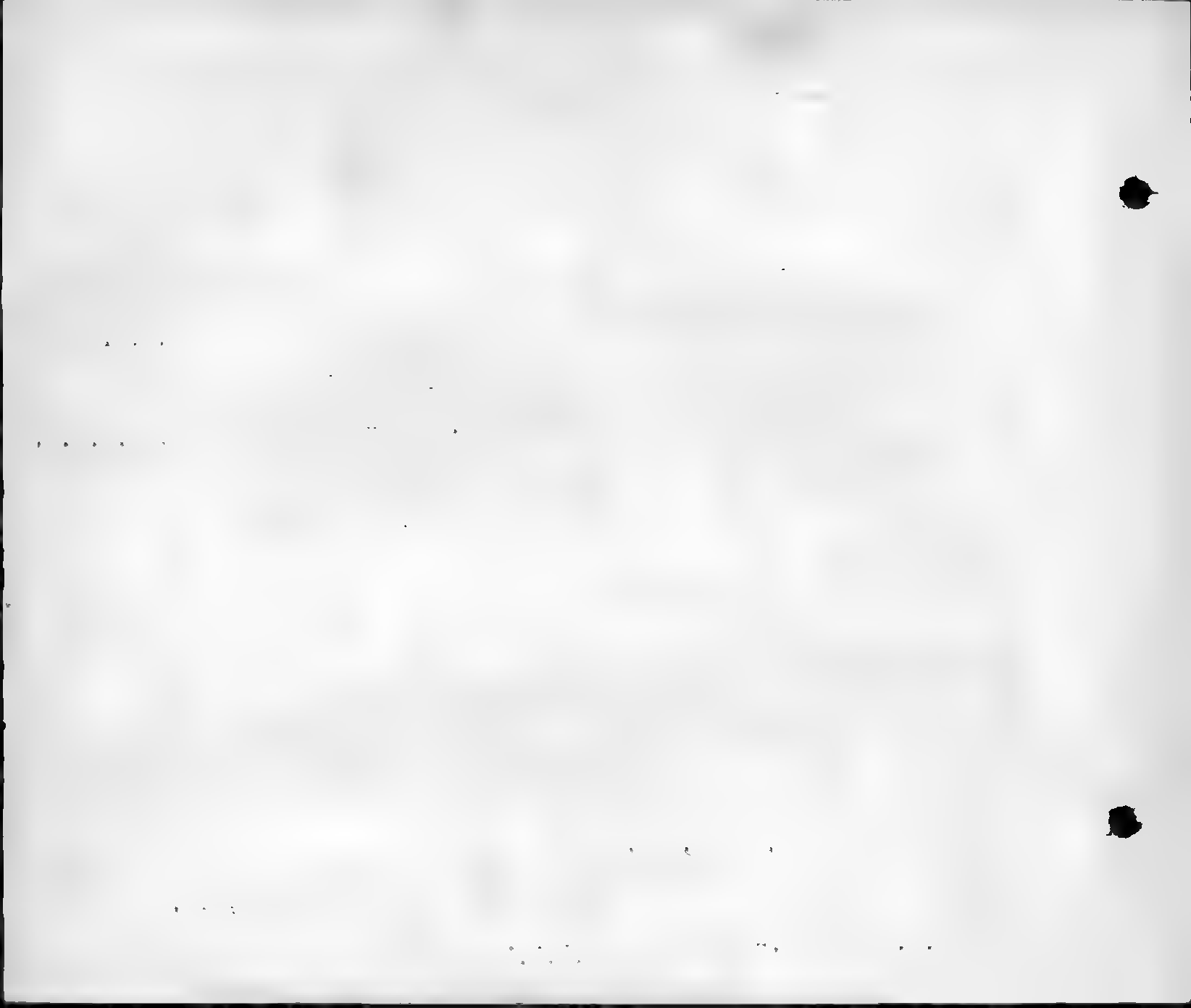
## 10373

## CERTIFICATE OF DEATH

Reg. Dist. No. **10516**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montgomery</b></span>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>910 Kennebec Street</b>				d. STREET ADDRESS <b>910 Kennebec Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <b>Katie May Wood</b>				<b>4. DATE OF DEATH</b> <span style="float: right;">Month Day Year</span> <b>September 20 1959</b>									
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9/22/1866</b>		<b>9. AGE</b> (In years last birthday) <b>92</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Michigan</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Hiram Barnes</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Julia Robinson</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>no</b>		<b>17. INFORMANT</b> <b>George A. Wood - 174 Old Court House Road New Hyde Park, L.I.N.Y.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>DUPLICATE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>11 years</b> (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I attended the deceased from</b> <b>Jan 1959</b> <b>to</b> <b>Sept 20, 1959</b> , <b>that I last saw the deceased alive on</b> <b>Sept 19, 1959</b> , <b>and that death occurred at</b> <b>11:30 P.M.</b> , <b>from the causes and on the date stated above.</b> <b>ADDRESS (Street, city or town, State)</b> <b>DATE SIGNED</b>													
<b>ACTUAL SIGNATURE</b> <b>William T. Gill, Jr.</b>						<b>PHYSICIAN'S NAME (Type)</b>							
<b>22a. BURIAL, CREMATION, or other disposition</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>9/23/59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Glenwood Cemetery</b>				<b>22d. LOCATION (City, town, or county)</b> (State) <b>Washington, D.C.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE SEP 22 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles E. Hines</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

10535

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b> <b>47x</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> <b>47x</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Nursing Home.</b>		d. STREET ADDRESS <b>31-15th Street N.E.</b>	
3. NAME OF DECEASED (Type or print) First <b>NORA</b> Middle <b>Wood</b> Last <b>Wood</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>14th.</b> Year <b>1959</b> <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1869</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, Pa.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hogue</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>390-106-P</b>	
17. INFORMANT <b>Miss Lulu Hogue</b>		Address <b>31-15th St. N.E. (sister)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Suppurative Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO <b>Pericarditis</b> (c) <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b) and (c). <b>1 mo.</b> <b>3 mo.</b> <b>4 mo.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/13/59</b> to <b>9/14/59</b> , that I last saw the deceased alive on <b>9/13/59</b> , and that death occurred at <b>3:00</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>31-15th St. N.E. Washington, D.C.</b> DATE SIGNED <b>9/14/59</b>			
ACTUAL SIGNATURE <b>Sam Allen</b>		M.D. <b>Sam Allen M.D.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, OR OTHER DISPOSITION <b>REMOVAL TO CEMETERY</b>		22b. DATE THEREOF <b>9-16-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.Wm. Lee's Sons Co</b>		ADDRESS <b>300-4th St. N.E.</b>	
24a. REC'D BY REGISTRAR <b>SEP 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10518

10536

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Pierce</b> 482-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>104 Indian Hills Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Vickie</b> Middle <b>Diane</b> Last <b>Young</b>				4. DATE OF DEATH Month <b>September</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1954</b>		9. AGE (In years last birthday) <b>5</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John H. Young</b>				14. MOTHER'S MAIDEN NAME <b>Gladys Eller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphocytic leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>1 yr</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 23</b> , 19 <b>59</b> , to <b>September 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>September 27</b> , 19 <b>59</b> , and that death occurred at <b>8:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>National Institutes of Health Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>Arthur R. Rothman, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Arthur R. Rothman, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>W. W. Chambers Co. 1400 CHAPIN ST. NW Wash., D.C.</b>		22d. LOCATION (City, town, or county) (State) <b>Atlanta, Ga.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur R. Rothman</b>	

CERTIFICATE OF DEATH

1933

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		35		Jan 1, 1898		New York City	
Cause of Death		Disease		Symptoms		Duration		Place of Death	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		2 days		Home	
Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
Jan 15, 1933		Home		[Signature]		[Signature]		[Signature]	
Occupation		Education		Religion		Marital Status		Social Status	
Teacher		High School		Catholic		Married		Middle Class	
Previous Illnesses		Previous Operations		Previous Accidents		Previous Habits		Previous Occupations	
None		None		None		None		None	
Medical History		Family History		Social History		Environmental History		Other History	
None		None		None		None		None	
Autopsy		Burial		Cremation		Disposition of Body		Disposition of Organs	
No		Yes		No		Buried		None	
Burial Place		Crematorium		Disposition of Body		Disposition of Organs		Disposition of Body	
Catholic Cemetery		None		None		None		None	
Disposition of Body		Disposition of Organs		Disposition of Body		Disposition of Organs		Disposition of Body	
None		None		None		None		None	
Disposition of Body		Disposition of Organs		Disposition of Body		Disposition of Organs		Disposition of Body	
None		None		None		None		None	

Page 4  
death.  
within 24 hours  
by the funeral director,  
Pages 1 and 2 should be filed with  
carbon copies.  
Then please remove carbon copies.  
within 72 hours after death.  
The low requires that the death certificate be executed within 24 hours  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies.  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10537

CERTIFICATE OF DEATH

Reg. Dist. No.

10519

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>7 days 11 hrs.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>10511 Wheatley Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Janis</b> Middle <b>Zvirbols</b> Last <b>Zvirbols</b>		4. DATE OF DEATH Month <b>September</b> Day <b>16</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 16, 1887</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Suburban Trust</b>		11. BIRTHPLACE (State or foreign country) <b>Latvia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Latvia</b> ✓		13. FATHER'S NAME <b>Carl Zvirbulis</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-46-0058</b>		INFORMANT (Daughter) <b>Vija Boniewicz</b> Address <b>As above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>years</b>	
21. I certify that I attended the deceased from <b>Sept. 9, 1959</b> to <b>Sept. 16, 1959</b> that I last saw the deceased alive on <b>Sept. 15, 1959</b> , and that death occurred at <b>3:15</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rockville, Maryland</b> DATE SIGNED <b>9/16/59</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>G. Beoditch Hunter, Jr.</b>		M.D. <b>Rockville, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>G. Beoditch Hunter, Jr.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/19/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orin E. Kline</b>			

CERTIFICATE OF MARRIAGE

1927

I hereby certify that on the 10th day of June 1927, at the City of New York, in the County of New York, the following persons were by me lawfully joined together in Holy Matrimony according to the rites and ceremonies of the Episcopal Church, as follows:

John Doe, of the County of New York, State of New York, and Jane Smith, of the County of New York, State of New York.

Witness my hand and the seal of the said Church at New York, this 10th day of June 1927.

Minister of the Gospel, [Signature]

Witness my hand and the seal of the said Church at New York, this 10th day of June 1927.

Minister of the Gospel, [Signature]